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ABSTRACT

This document contains witness testimonies and prepared statements from the Congressional hearing called to examine problems in the partnership of Medicare and Health Maintenance Organizations (HMO's). Opening statements are included from committee chairman Claude Pepper and from Representative Lawrence J. Smith. Two panels of witnesses address the problems of HMO's and Medicare. Members of the first panel, consisting of attorneys from Legal Services of Greater Miami, Inc., and from the National Health Law Program, Inc., and a daughter of former HMO members, cite examples of problems encountered by clients and family members while trying to use HMO or Medicare services. Also testifying is the associate director of the Human Resources Division, General Accounting Office (GAO), who reports findings from the GAO investigation of the Health Care Financing Administration's (HCFA) oversight of four demonstration projects in Florida and recommends improvements in government management and oversight efforts. The second panel, presenting the Federal response to the GAO report, consists of three representatives from the Department of Health and Human Services: the administrator and a special assistant from the HCFA and the director of the Office of Health Maintenance Organizations. Problems discussed include processing time involved in enrollments and disenrollments of Medicare beneficiaries, the susceptibility to errors of the HCFA's system for coordinating payments to physicians and hospitals, and errors in claim payments. The appendices contain the GAO report, "Problems in Administering Medicare's Health Maintenanace Organization Demonstration Projects in Florida," and additional materials submitted for the record. (NRB)

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HMO'S AND MEDICARE: PROBLEMS IN THE OVERSIGHT OF A PROMISING PARTNERSHIP

ED264447

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

APRIL 24, 1985

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HMO'S AND MEDICARE: PROBLEMS IN THE OVERSIGHT OF A PROMISING PARTNERSHIP

WEDNESDAY, APRIL 24, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:05 a.m., in room 2337, Rayburn House Office Building, Hon. Claude Pepper (chairman of the subcommittee) presiding.

Members present: Representatives Pepper, Borski, Regula, Wortley, Courter, Schneider, Boehlert, Lightfoot, Meyers, and Kolbe.

Also present: Representative Lawrence J. Smith.

Staff present: Kathleen Gardner Cravedi, staff director; Melanie Modlin, assistant staff director; Peter Reinecke, research director; Patrick McCarthy, congressional fellow; Tom Bazley and Ronald Schwartz, detailees; Mary Toole, intern; Julia Kingston, volunteer; Mark Benedict, minority staff director; and Anne Riser, minority staff assistant.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. PEPPER. The committee will come to order please.

We are glad to have all of you with us this morning to hear the testimony which will be presented by able witnesses and to consider this important matter.

We are here today to look into a matter of great concern to our Nation's 29 million Medicare beneficiaries—a very promising partnership between the Medicare Program and the health maintenance organizations, HMO's. Recognizing the advantages offered by HMO's over the past decade, Congress has encouraged their development and expansion of their availability to the elderly through Medicare. As a matter of fact, it is what we call demonstration projects that have been on. Because of this effort, HMO's have grown in number and membership. Today there are over 300 HMO's around the Nation with 15 million members. However, only a limited number of senior citizens have been able to take advantage of HMO's by being given the option of replacing their regular Medicare coverage with membership in an HMO.

You will recognize that one of the distinct advantages of the HMO to the elderly is that Medicare does not provide for preventive care; that is, checkups. The HMO's do. To what extent, varies among the HMO's. They must carry out that responsibility to a full degree if they have it.

In order to increase incentives for HMO's to enroll Medicare beneficiaries, Congress included in the Tax Equity and Fiscal Responsibility Act of 1982, a provision changing the way in which Medicare would pay for HMO membership. Just over 2 months ago, the Department of Health and Human Services issued final regulations implementing this provision.

With the coming expansion of this promising partnership, it is critical that we take this opportunity to closely scrutinize what the Federal Government has done and will be doing to ensure its successful management. A recent report of the General Accounting Office and a subsequent investigation by the Subcommittee on Health and Long-Term Care, this subcommittee, revealed serious inadequacies in the Federal Government's current and planned oversight activities related to Medicare-participating HMO's.

Remember that when the HMO's take over the responsibility of giving the medical care the law provides to be given to Medicare patients through Medicare, that is all those individuals are going to get. Medicare doesn't come along behind and give what the HMO doesn't give. All the elderly get is what the HMO provides and the Federal Government pays 95 percent of the average cost to the Medicare Administration of providing Medicare covered services to the elderly people of the country.

The General Accounting Office report, undertaken at the request of my distinguished colleague, the Honorable Larry Smith, whom we are pleased to have with us here today, identified the problems in the Health Care Financing Administration's oversight of four demonstration projects in the south Florida area. The GAO's study of these 4 HMO's, of the 32 demonstrations around the country, revealed that nearly three-fourths of a million dollars was wasted in overpayments, and that a number of senior citizens were left with unpaid medical bills and denied the care they needed.

A recent study by this subcommittee indicates that the types of problems identified by the GAO have not been limited to the south Florida area alone. HMO's around the Nation participating in the demonstration program have had and continue to have problems with HCFA's handling of the program.

I have received letters and telephone calls from senior citizens and their advocates, HMO's, hospitals, home health agencies, and physicians from California, Florida, Michigan, Minnesota, Oregon, and elsewhere indicating this. It appears to be clear that the problem is not with the concept being tested, but rather related to the way the test has been structured and managed by the Health Care Financing Administration.

Some examples of problems identified by the subcommittee include: A 70-year-old Spanish-speaking woman, debilitated by arthritis, has spent 2½ years trying to straighten out a computer error that has had her listed as a member of an HMO she never joined. Despite numerous assurances from HCFA that the problem had been corrected, she is to this day still listed as an HMO member on the HCFA computer in Baltimore. Because of these foulups, Medicare has continually refused to pay her doctor's bills, leaving her with large outstanding bills and threats from doctors that she will be refused treatment. This elderly woman has suffered needlessly for circumstances completely beyond her control.

In the next instance, an 88-year-old widow from Long Beach, CA, has been left with medical bills far beyond her means because of confusion and delays with her enrolling and disenrolling from a local HMO. Frightened, confused, and angered, she did not know why Medicare was refusing to pay her medical bills.

You know, once the transfer has occurred; once the individual has been transferred over to the HMO from Medicare, of course, Medicare looks to the HMO to pay the bills.

An elderly man from Fort Lauderdale, FL, died while awaiting notification that a life-threatening condition would be reimbursed by Medicare. Following his death, it took no less than 7 months for his widow to be reinstated on the Medicare rolls.

We will hear today some of these sad stories. We will also hear from the General Accounting Office as to the findings of their investigation and their recommendations for improving Government management and oversight.

In spite of their own projections of dramatic growth in HMO participation with the Medicare Program and the nature of the problems that have been identified, the two Government agencies responsible for the oversight of Medicare-participating HMO's, the Health Care Financing Administration and the Public Health Service, are planning cutbacks in their efforts. In other words, they are not going to give better supervision; they are going to give less.

In its fiscal year 1986 budget justification, HCFA states that the new emphasis on HMO's and their rapid growth requires an extensive audit effort. Several pages later, this same document states the HCFA's audit effort for HMO's and other facilities will be reduced by over a third next year.

The Public Health Service, which is responsible for overseeing Federal qualifications of HMO's, has planned to cut about one-third of its staff within the Office of Health Maintenance Organizations. The administration, faced with the clear need for increased and improved effort, is cutting it back.

Today we will hear from HCFA and PHS concerning their oversight efforts.

Steps, therefore, must be taken to strengthen and improve this promising partnership still in its infancy. To this end, some 2½ years ago, I introduced legislation calling for the testing of "freedom-of-choice" HMO's. This bill, which I recently reintroduced, will simplify the enrollment process and allow seniors to go to their own doctor, as well as HMO doctors, without referral or authorization by the HMO.

I will introduce today another bill. This legislation will cut to 2 weeks the maximum amount of time allowed between a Medicare enrollee's request to get out of the HMO and their return to standard Medicare coverage. Now the period is anywhere from 1 to 2 months and a lot of confusion results from this. Whose responsibility is it to look after the individual and the like?

I don't see why, with modern technology available, we couldn't cut it down to 2 weeks and diminish the uncertainty to the patient as to who is responsible for his or her care. We must, therefore, put forth a determined effort to ensure our Nation's senior citizens the type of comprehensive health care they so rightfully deserve. We

cannot allow Government mismanagement and lack of will endanger this.

I think the HMO concept is one of the great breakthroughs in providing better medical care to elderly people. Just like most other organizations that have the responsibility of rendering critical services though, the government, both State and Federal, needs to keep a sharp eye upon their performance to be sure that the contract is being carried out; to be sure the institution is being well managed; to be sure people are getting the care that they are supposed to get. The Government is the one primarily responsible for that supervision. That is what we are here to talk about today.

I mentioned before my distinguished colleague, Mr. Smith, came in that it was he who introduced the proposal—that is, he called upon the GAO to make the inquiry and the investigation which is the subject of this hearing today.

Now Mr. Smith is with us and I welcome his statement.

STATEMENT OF REPRESENTATIVE LAWRENCE J. SMITH

Mr. SMITH. Thank you, Mr. Chairman.

I want to thank you and the staff, not only for scheduling this hearing today, but also for the cooperation and the interest in this very important subject that you have shown throughout the years since the time that the demonstration projects were initially put on line as a result of the 1981 law, which created the authority for the Medicare beneficiaries to be treated by HMO's.

I have an opening statement which I would like to read partially. It is a little bit long and so I will skip parts and would request consent to place it in full in the record.

Mr. PEPPER. Without objection, it will be included in full in the record.

Mr. SMITH. Thank you, Mr. Chairman.

I want to thank Congressman Pepper for holding this hearing at my request, on the Health Maintenance Organization/Medicare Program. I know he is committed, as I am, to providing senior citizens with access to affordable quality health care. This hearing will offer us an opportunity to explore the experiences of HMO/Medicare demonstration projects across the country, as well as to discuss the results of the General Accounting Office's interim report on the systemic problems in the Florida demonstration project.

Although I am not a member of this committee, my interest in this issue is longstanding. The impetus behind my involvement is my desire to ensure that the HMO/Medicare Program has every opportunity to fulfill its potential and become an affordable alternative for delivery of quality health care for our elderly. I might add at this point that both Senator Pepper and myself represent an area which has a large number of elderly constituents, and as a result, our interest is not only for the benefit of the United States, but frankly, quite parochial for the benefit of large numbers of senior citizens who live in our area.

Let me briefly trace the events that have led to this hearing. In 1982, TEFRA permitted Medicare beneficiaries to receive care from HMO's under a new reimbursement system. HMO/Medicare demonstration projects were set up in 26 geographic locations around

the country and have approximately 200,000 elderly enrolled. Demonstration projects in Florida began in August 1982.

Let me add here that the TEFRA law does not specifically mandate demonstration projects and, frankly, I would commend HHS and HCFA for originally setting up the demonstration projects to determine, I assume, the viability and feasibility of the program passed under the TEFRA law.

From the start of the demonstration projects to this very day, my office has received numerous complaints about the program. These complaints have come from all affected parties: providers, doctors, beneficiaries, hospitals, home health agencies and the like, including some of the HMO's providing of care under contract with the Government.

The number the complaints we received and the tragic stories of incompetence, mismanagement, insensitivity and irresponsibility that many of them told made it clear that problems existed in the program. We have been constantly frustrated by an inability to obtain adequate information from the Health Care Financing Administration, or HCFA, the agency overseeing this program.

HCFA representatives made it clear to me on several occasions, including the Select Committee on Aging's field hearing in Boca Raton, FL, that HCFA was content to proceed with plans for national expansion of this program without looking at any statistical data on the demonstration projects. I was told that the national expansion of the program is "not contingent upon the demonstration." As a matter of fact, at the field hearing, when I asked Mr. Fowler, of HCFA What statistics had been collected and analyzed, he told me that none, in fact, had been collected, and after 2 years of the program, the only thing they could really tell us with certainty were how many people were enrolled in the program, and practically nothing else. That was rather disturbing.

Regulations were slated to go into effect February 1 of this year, making this a national option for all Medicare beneficiaries, approximately 27 million Medicare beneficiaries. Contrary to what HCFA believes, it is absolutely essential that we look at the demonstration projects in order to ensure that HMO Medicare option operates smoothly before it expands nationally, since 2 to 3 million Medicare beneficiaries may sign up in just the next year alone for HMO care nationwide, which would be a tenfold to fifteenfold increase over what now exists in terms of the number of people that are in the system.

I felt that Florida's experience could yield valuable information, if only the Federal Government would collect it and analyze it. No other area has the same population concentration as Florida, or the sheer numbers of senior citizens enrolled in this project, 112,000. It seems obvious to me that if the program cannot handle the volume of 112,000 senior citizens without problems, then there is no possible way it can handle 2 to 3 million additional elderly participants and, remember, that is only in the next year or so. For whatever reasons, HCFA has failed to recognize the Florida program and its problems in that light.

Therefore, I requested a GAO review of the program as it operated in Florida. I was joined in this request by Representatives Gibbons, Fascell, Mica, MacKay, Shaw, and Lewis of Florida. We re-

quested that GAO address the following issues as they relate to the Florida HMO/Medicare Program, and there is a list here which I will not go over.

A year passed and GAO had not yet completed its study of these issues. I appealed to HCFA to delay expanding the program nationally until the results of the investigation were known. HCFA refused, reiterating their belief that there are no problems with the demonstration projects. It became clear to me that the Department of Health and Human Services and HCFA were closing their eyes to any problems in the system.

Secretary Heckler stated she believed this program was too important to hold up because of the problem in one State. She said she would take care of the Florida problem, something, I might add, she has yet to do.

Because of HCFA's refusal to delay implementation of the regulations to expand the program nationally, I requested GAO release an interim report dealing only with the administrative problems with the program, the most important problems to correct before expansion.

I might add that the reason I asked for an interim report was that GAO had great difficulty—as I am sure you will hear later from the witnesses who are here from GAO—had great difficulty ferreting out the information. There is such a lack of coordinated information-keeping and a lack of interfacing among information systems in all the various parts of this program, that they literally had to go in and do tracking by hand on spread sheets, something very unusual for a modern technological system.

The interim report released on March 8 of this year showed that something does need to be done by the administrative agencies now. Sadly, the report confirmed everything we had suspected concerning HCFA's willingness to greatly expand a program that does not yet have the capacity to fulfill its promise. It has taken the GAO over a year to research just the administrative problems because of the sloppy and poorly managed recordkeeping and administration of the program.

The thrust of the report is that the Federal Government does not have an administrative process in place and knows that it does not. An internal HCFA memo revealed that the agency was aware in 1982 of their computer's inability to properly manage this important program, yet I have seen no evidence that these problems have been resolved effectively. Let's keep in mind that the program has been in existence for 3 years and that the problems have existed from the start and keep in mind that now they are going to have maybe 1,500- to 2,000-percent increase in the number of beneficiaries entitled to participate in that program by virtue of the new regulations nationwide.

Where do we stand today? We have a GAO report which confirms that a number of changes promptly must be made in the administration of the HMO/Medicare Program in order to remedy what ails it. Despite the number of problems and complaints that have been brought to HCFA and to the HHS, there has been a refusal to hold back on the national expansion of this program until an administrative system to handle it has been brought properly

on line, until the information from the demonstration project can be properly analyzed and until the GAO report can be completed.

This, I submit to you, is both irresponsible and an invitation for this important program to come crashing down around us. One of the witnesses who will tell her story today is a constituents from my district, Helen Sposa. She has come to tell her story because of the magnitude of the problems she and her parents-in-law faced in dealing with the HMO/Medicare problem. My office has worked extensively with her for 7 months to try to remedy the problems she has faced. These problems, I might add, have not yet been entirely resolved. Helen and her mother-in-law are still waiting to be reimbursed for hundreds of dollars in hospital bills owed to her by Medicare. She will tell you her story herself in a few minutes.

As you listen to her story and the stories of others, keep in mind that these are just the tip of the iceberg; examples of problems that on paper often look very dry, but can have a personal and devastating effect on senior citizens and their families when they are forced to deal with them.

I also might add, problems which have an effect of ultimately draining millions of dollars from the system in double payments, lack of correct billings, lack of receipt of double payments and the like. Many of the problems with the demonstration projects are regulatory in nature. They have been caused by mismanagement, lack of planning, underestimation of needed resources, inadequate computer capacity, regulatory loopholes that have been ignored and often just plain failure to enforce existing regulations all on the part of our Government.

A major administrative problem that HCFA must resolve is the inadequate computer capability. It is essential that HCFA develop and implement immediately an adequate method of interface between computers at Social Security, HCFA regional offices, intermediaries and carriers, HMO projects and HCFA's Baltimore office. It is ludicrous to assume that this program can operate effectively without the availability of up-to-date and compatible information resources for the use of all parties involved.

I have a number of legislative proposals which I have put forth in my statement which will be printed in the record. I would like to just say in closing that we all want to see this program succeed. Today, we are faced with the unique opportunity to examine it and encourage the changes necessary to ensure its success. We need to take this opportunity to examine the administrative requirements of the program to ensure that it has the resources, the staff, the computers, and the administrative system capable of making it a positive cost-effective addition to our senior citizen health care delivery system.

Let's do this properly now while the program is in its infancy, instead of waiting until we have created another bureaucratic monster fraught with waste, fraud, and abuse, which eventually will crack under its own weight. The elderly deserve quality health care. The health maintenance organization/Medicare option may be one way to provide it and save money for the Medicare system.

Thank you very much, Mr. Chairman.

[The prepared statement of Representative Smith follows:]

PREPARED STATEMENT OF REPRESENTATIVE LAWRENCE J. SMITH

I want to thank Congressman Pepper for holding at my request this hearing on the Health Maintenance Organization/Medicare Program. I know he is committed, as I am, to providing senior citizens with access to affordable, quality health care. This hearing will offer us an opportunity to explore the experiences of HMO/Medicare demonstration projects across the country as well as to discuss the results of the General Accounting Office's interim report on the systemic problems in the Florida Demonstration Projects.

Although I am not a member of this Committee, my interest in this issue is longstanding. The impetus behind my involvement is my desire to ensure that the HMO/Medicare Program has every opportunity to fulfill its potential and becomes an affordable alternative for delivery of quality health care for our elderly.

Let me briefly trace the events that have led to this hearing.

In 1982, the Tax Equity Fiscal Responsibility Act (TEFRA) permitted Medicare beneficiaries to receive care from HMOs under a new reimbursement system.

HMO/Medicare demonstration projects were set up in 26 geographic locations around the country and have approximately 200,000 elderly enrolled. Demonstration Projects in Florida began in August of 1982.

From the start of the Demonstration Projects to this very day, my office has received numerous complaints about the program. These complaints have come from all affected parties—providers, doctors, beneficiaries, hospitals, home health agencies, etc. The number of complaints I received and the tragic stories of incompetence, mismanagement, insensitivity and irresponsibility that many of them told, made it clear that problems existed in this program.

I have been constantly frustrated by an inability to obtain adequate information from the Health Care Financing Administration (HCFA), the agency overseeing this program. HCFA representatives made it clear to me on several occasions, including the Select Committee on Aging's filed hearing in Boca Raton, Florida, that HCFA was content to proceed with plans for national expansion of the program without looking at any statistical data on the demonstration projects. I was told that the national expansion of the program is "not contingent upon the demonstration."

Regulations were slated to go into effect February 1, 1985 making this a national option for all Medicare beneficiaires. Contrary to what HCFA believes, it is essential that we look at the demonstration projects in order to ensure that the HMO/Medicare option operates smoothly before it expands nationally, since 2 to 3 million Medicare beneficiaires may sign up in the next year for HMO care nationwide.

I felt that Florida's experience could yield valuable information—if only the Federal Government would collect and analyze it. No other area has the same population concentration as Florida or the sheer numbers of senior citizens enrolled—112,000. It seems obvious to me that if the program cannot handle a volume of 112,000 senior citizens—there is no possible way that it can handle 2 to 3 million additional elderly participants. For whatever reasons, HCFA has failed to recognize the Florida program and its problems in that light.

Therefore, I requested a General Accounting Office (GAO) review of the program as it operated in Florida. I was joined in this request by Reps. Gibbons, Fascell, Mica, MacKay, Shaw and Lewis of Florida.

We requested that GAO address the following issues as they relate to the Florida HMO/Medicare Program:

1. Financial responsibility and marketing and advertising methods; 2. enrollment and disenrollment procedures; 3. emergency service procedures; 4. quality of care assurance; 5. method of determination of Medicare premium rates; 6. grievance procedures; and 7. how Florida's demonstration projects compare with those in other areas.

A year passed and GAO had not yet completed its study of these issues. I appealed to HCFA to delay expanding the program nationally until the results of GAO's investigation were known. HCFA refused—reiterating their belief that there are no problems with the demonstration projects. It became clear to me that the Department of Health and Human Serivces and its Health Care Financing administration were closing their eyes to any problems in the system. Secretary Heckler stated that she believed that this program was too important to hold up because of the problems in one state. She said she would take care of the "Florida problem.", something, I might add, she has yet to do.

Because of HCFA's refusal to delay implementation of the regulations to expand the program nationally, I requested that GAO release an interim report dealing only with the administrative problems with the program—the most important problems to correct before expansion.

The interim GAO report, released on March 8, 1985, showed that something does need to be done by the administrative agencies now. Sadly, the report confirmed everything we had suspected concerning HCFA's willingness to greatly expand a program that does not have the capacity to fulfill its promise. It has taken the GAO over a year to research just the administrative problems of the system because of the sloppy and poorly-managed recordkeeping and administration of the program.

The thrust of the interim report is that the Federal Government does not have an administrative process in place and knows it. An internal HCFA memo revealed that the agency was aware in 1982 of their computer's inability to properly manage this important program. Yet, I have seen no evidence that these problems have been resolved effectively—and let's keep in mind that the program has been in existence for three years and that the problems have existed from the start.

Where do we stand today? We have a GAO report which confirms that a number of changes promptly must be made in the administration of the HMO/Medicare Program in order to remedy what ails it. Despite the number of problems and complaints that have been brought to HCFA and HHS' attention—there has been a refusal to hold back on the national expansion of this program until an administrative system to handle it has been brought properly on line, until the information from the demonstration project can be properly analyzed, and until the GAO report can be completed. This, I submit to you, is both irresponsible and an invitation for this important program to come crashing down around us.

One of the witnesses who will tell her story today is one of my constituents, Helen Sposa. She has come to tell her story because of the magnitude of the problems she and her parents-in-law faced in dealing with the HMO-Medicare program. My District Office has worked extensively with Helen for 7 months to try to remedy the problems she has faced. These problems I might add have not yet been entirely resolved. Helen and her mother-in-law are still waiting to be reimbursed for hundreds of dollars in hospital bills owed to her by Medicare. But she will tell you her story herself in a few minutes. As you listen to her story and the stories of others keep in mind that these are just the tip of the iceberg—examples of problems that on paper often look very dry but can have a very personal and devastating effect on senior citizens and their families when they are forced to deal with them.

Many of the problems with the demonstration projects are regulatory in nature. They have been caused by mismanagement, lack of planning, underestimation of needed resources, inadequate computer capacity, regulatory loopholes that have been ignored and often just plain failure to enforce existing regulations, all on the part of our government.

The major administrative problem that HCFA must resolve is the inadequate computer capability. It is essential that HCFA develop and implement immediately an adequate method of interface between computers at Social Security, HCFA regional offices, intermediaires and carriers, HMOs, and HCFA's Baltimore office. It is ludicrous to assume that this program can operate effectively without the availability of up-to-date and compatible information resources for the use of all parties involved.

Legislatively, I would recommend that the following changes be made:

1. Require HCFA to provide intermediaries with monthly updates on enrollment/disenrollments. The intermediaires should be required to provide this data to others in the health care chain. HCFA also should be required to audit intermediaries at regular intervals to ensure that this occurs.

2. Requrire all HMO's in the medicare program, which was expanded in February, 1985, to use standardized enrollment/disenrollment forms.

3. If a person signs an HMO enrollment form but is hospitalized before the effective date, Medicare should pick up the costs until the hospitalization ends. Enrollment would become effective after discharge.

4. Require HCFA to study its resouces to determine whether with current budgeted resources HCFA can meet projected administrative needs. HCFA also should study its computer system to determine an adequate method of interfacing with computers at Social Security Administration, intermediaries, hospitals, etc. Currently, SSA (Baltimore) and regional SSA offices do not have access to the same information. This creates confusion.

I would just like to say in closing that I want to see this program succeed. Today, we are faced with a unique opportunity to examine a program and encourage the changes necessary to ensure its success. We need to take this opportunity to examine the administrative requirements of the program to ensure that it has the resources—the staff, the computers and the administrative system—capable of making it a positive, cost effective addition to our senior citizen health care delivery system. Let's do this properly now while the program is in its infancy—instead of waiting

until we have created another bureaucratic monster fraught with waste, fraud and abuse, which eventually will crack under its own weight. The elderly deserve quality health care. The Health Maintenance Organization/Medicare option may be one way to provide it and save money for the medicare system.

Mr. PEPPER. Thank you very much.

Mr. SMITH. And I want to commend you once again as the preeminent light in this country in not only protecting the rights of the elderly, but in making sure that the elderly from day to day have the quality health care that they are entitled to.

Mr. PEPPER. Thank you, Mr. Smith. They are fortunate to have a great warrior like you fighting their battles also.

Mr. Courter, would you have any statement?

Mr. COURTER. Thank you, Mr. Chairman. I enjoyed the opening statement of Congressman Smith. I have nothing to add and look forward to the testimony.

Mr. PEPPER. Thank you.

Ms. Meyers, do you have a statement?

Mrs. MEYERS. No; thank you.

Mr. PEPPER. Thank you very much.

We will call, then, the first panel. Mrs. Cindy Huddleston, attorney, Legal Services of Greater Miami, Miami, FL—Cindy is on the end here. Mr. Michael Parks, attorney, National Health Law Program, Los Angeles. Mr. Parks is in the middle. Ms. Helen Sposa, daughter of a former HMO member in Fort Lauderdale, to whom Mr. Smith referred in his testimony.

Mrs. Huddleston. we will start off with you if we may.

PANEL ONE—THE PROBLEM AND THE INVESTIGATION: CONSISTING OF CINDY HUDDLESTON, ATTORNEY, LEGAL SERVICES OF GREATER MIAMI, INC., MIAMI, FL; MICHAEL PARKS, ATTORNEY, NATIONAL HEALTH LAW PROGRAM, INC., LOS ANGELES, CA; AND HELEN SPOSA, DAUGHTER OF FORMER HMO MEMBERS, FORT LAUDERDALE, FL

STATEMENT OF CINDY HUDDLESTON

Ms. HUDDLESTON. My name is Cindy Huddleston. I am an attorney with Legal Services of Greater Miami, practicing in the areas of health and public benefits. At Legal Services, we work frequently with elderly Medicare beneficiaries who have experienced problems when enrolling in or disenrolling from HMO's. This morning, I would like to share with you the stories of several of our elderly clients who have experienced such problems.

In January 1983, a 70-year-old Spanish-speaking client of ours began to receive notices from Medicare telling her that Medicare would not pay for her doctor's bills because she was an HMO member. This woman had never joined an HMO. She did not even know what an HMO was. After several inquiries on her behalf, we learned that she had somehow mistakenly been listed as a member of an area HMO on the Medicare computer in Baltimore. During the time that she was incorrectly listed as an HMO member, she could not get the medical treatment she needed from some of her doctors. They refused to treat her unless she paid in full out of her own pockets. This elderly woman is indigent and certainly could not afford to pay for this treatment.

Some 17 months after Medicare began refusing to pay for her bills, she was told by Medicare that the problem had been straightened out and her name removed from the HMO roll. Three months later, her name reappeared as an HMO member on the Medicare computer and Medicare once again began to deny her doctor's Medicare claims. Just last week, this same woman notified us that she had again received a denial notice from Medicare stating that she was an HMO member. This has been going on for nearly 2½ years now and nothing has changed.

Our office was also contacted by a 67-year-old woman on Medicare whose request for disenrollment from an area HMO had been pending for 8 months. Because she believed she had been put back on regular Medicare coverage, she went to a private hospital for treatment should needed. After being admitted, this woman was forced to leave the hospital because a computer check identified her as an HMO member.

Unfortunately, she had already incurred considerable hospital and doctor bills. Many of her creditors turned over her bills to collection agencies. Many threatened to sue her. She was finally disenrolled retroactive to the appropriate month. However, retroactive disenrollment in no way made up for her embarrassment when bills were turned over for collection or for her inability to get the medical care she needed.

We are often contacted by Medicare recipients who have been left with large medical bills from outside their HMO after requesting disenrollment from the HMO, but before the effective date of disenrollment. These senior citizens do not realize that they are not immediately disenrolled upon request. Even though HMO's usually give written notice of the waiting period, this notice is not sufficient for those members who are illiterate or unable to communicate in English. One of our elderly Spanish-speaking clients had eye surgery performed at a private hospital after he had requested disenrollment, but before his disenrollment from the HMO became effective. The form for requesting disenrollment which he had filled out was written in English. He had not been informed of the waiting period and thought that Medicare would pay for this surgery. His medical bills from this hospitalization are in excess of $7,000. The HMO refuses to pay his bills because the services were not an emergency and Medicare refuses to pay because he was still an HMO member. His creditors are now threatening to sue him.

We have also been contacted by senior citizens about other types of problems with HMO's. At Legal Services, we frequently learn of HMO's enrolling unsuspecting and often illiterate or obviously incompetent elderly people who believe that they are simply requesting additional information about the HMO. I have been told by an HMO claims representative that the HMO routinely will deny payment for out-of-plan services, even if bills are for emergency care. We have also received complaints about the quality of care and the long time it takes HMO's to schedule appointments for members needing medical treatment. Several of our clients have complained that computer checks identified them as HMO members, even though they have never enrolled. For example, several months ago, an elderly Medicare beneficiary came to my office covered with open, bleeding sores. This woman had been denied treatment at a

local hospital the day before because a computer check showed her to be an HMO member. She had never enrolled in an HMO. The HMO confirmed that she had never enrolled.

In concept, HMO's are efficient and cost-saving. In practice, there are problems that need attention. Since both the physical and mental health of elderly and disabled Medicare recipients is at stake, HMO's which provide services to Medicare recipients should be held to a very high standard. Enrollment and disenrollment procedures must be managed more efficiently. Compliance with Federal standards should be monitored carefully and frequently. This is something that I am not aware is being done.

Thank you.

Mr. PEPPER. Thank you very much, Ms. Huddleston.

We will hear all the panel before we question, if we may.

Mr. Parks, we would be pleased to hear you.

STATEMENT OF MICHAEL PARKS

Mr. PARKS. Thank you, Mr. Chairman, and members of the committee and Representative Smith. Good morning.

My name is Michael Parks. I am an attorney with the National Health Law Program, a legal services support center located in Los Angeles and I am also affiliated with a Medicare advocacy project in the same city.

In those capacities, I have studied the problems of Medicare beneficiaries in HMO's, both in my area, as well as in south Florida. Based on my work, it is clear to me that many Medicare beneficiaries have experienced serious problems with the as-yet limited and agreedly promising partnership between Medicare and HMO's.

I would like to describe the plight of a few Los Angeles recipients that I am familiar with, to add their circumstances to the other circumstances that witnesses and the Congress people have been mentioning.

One couple, an elderly couple in their seventies, sought to enroll in an HMO. One of their primary concerns was that the wife, who was very dependent on a physician she had a longstanding relationship with, would be able to continue to see that physician. When the husband called the HMO, given the number that they supply for information about enrollment, he was told that, yes, that would still be possible.

Once they were actually enrolled, he learned that, in fact, that physician was not involved with the HMO and he immediately disenrolled, but because of the time lag that, Senator, you pointed out is involved in disenrollment, a few months passed; he never used the HMO, but did incur a couple of hundred dollars in bills on the outside.

The man was so furious and so upset over this—what he thought was duplicitous conduct—that he has not wanted to pursue that matter. He wants to wash his hands of it.

You yourself mentioned the situation of an 88-year-old widow from Long Beach who "was enrolled in an HMO" against any knowledge that she had of the fact. She first learned of being in the HMO when some months later the Medicare administration

denied claims for doctor bills of a couple of hundred dollars that she had incurred while officially enrolled in the HMO.

All she remembers is that someone came to her house one time, talked about her health coverage, and asked to see her Medicare card. But, of course, she was enrolled and several months passed before she was able to get out of the HMO officially, and this person is frustrated and aggravated. We have tried to deal with the HMO to ask why they haven't covered services which were incurred during the interim and they never respond to our contacts and several months have passed.

A similar situation afflicted a man who I have referred to as Mr. S in the testimony, who lives in Culver City. He himself is incapable of managing his own affairs and his daughter-in-law, who herself is troubled by certain ailments, exercises the power-of-attorney for him. She insists that a mailing came to her house about an HMO; that she wrote off saying she wanted to get further information about it; and some months later, they learned that, in fact, this elderly man, who had no idea of the HMO concept, was enrolled. By the time that he disenrolled officially, he incurred some $1,000 worth of "out-of-plan services," which will not be reimbursed.

In each of these situations, which I think are typical of many, many people, not only has the Medicare Program paid several thousand dollars to these HMO's by way of capitation payments, but the individuals themselves have paid in confusion, anguish and personal liability, even though their only contact with these HMOs was the time they sought to officially disenroll. They never visited them; they never really knew much about them.

In my comments, and in the written testimony which I have submitted to the committee, I have tended to focus on these problems of informed enrollments, the problems of disenrollments and out-of-plan service liability. I have not addressed problems of access to and quality of care, which I think are important issues, but which I thought was beyond, for the moment, the subject of thise hearing.

In addition to the recommendations that the GAO had made and the kinds of legislation which yourself and Mr. Smith have mentioned they are introducing, which I think sound like wonderful ideas, there are other kinds of recommendations I have listed in my testimony, which I will not detail now because it is there in writing.

Let me just mention a couple of the types of problems which I think are happening to a lot of people which are not exactly stressed in the GAO's report. The first is that this problem of people being enrolled in HMO's, either without their knowledge or with inadequate knowledge, I think is extensive.

I think that the problems of rapidly processing disenrollments, which, Mr. Pepper, your proposed legislation would help remedy, is a serious problem, but beyond that, I think there is a tremendous problem of people knowing what it is they can do to resolve these problems that they have. Most people I talk to have no idea what it is they can do to solve any of these problems, and it is probably the primary reason why so few formal complaints are actually raised. People don't realize they have a problem that can be remedied and

the Health Care Financing Administration doesn't do anything about that.

I should add, also, that in my experience—and I think the experience of advocates elsewhere—it is extremely difficult to get any response from either the HMO's or the Health Care Financing Administration to rapidly address these complaints. For example, it has been mentioned in this room that the administration has run a demonstration project for a couple of years in south Florida and other States. The GAO report notes that many thousands of people have incurred personal liability for out-of-plan services during that experiment.

I know of nothing that the administration is doing to resolve those problems, and yet those are people that were hurt by this experiment, who have thousands of dollars of personal liability which they never should have had, suffered pain which probably can't be redressed, but still have these liabilities that the agency has known about for years and has done nothing about and I think they should resolve those people's problems.

Let me just say briefly that I think the GAO report does not yet stress some of the fundamental problems that result in these out-of-plan service difficulties and other problems that are similar which result from people not knowing that much about HMO's and how they operate. There is a tremendous volume of advertising that elderly people receive about HMO's which markets them rather than informs people about them. Now, that is well and good. Obviously, marketing has to take place by businesses, but I think the stress has been on marketing, with very little stress on informing, and people are very vulnerable—I find a lot of this advertising overly aggressive, misleading, and results in problems that we have seen and nothing is done about that.

In addition, you yourself have pointed out that the ability to disenroll promptly has been a problem. As I said, the difficulty in knowing that one has an appeal process for any of these things is a tremendous problem. As a general matter, the administration has not made clear to anyone, including advocates, let alone beneficiaries, what clear channels one has for speedily resolving any of these problems.

I think it is implicit in what I have said that behind all these specific difficulties, there is a tremendous problem of inadequate oversight and monitoring by the Federal Government: the Health Care Financing Administration and its parallel agencies. Their mission for a number of years has been to promote the growth of HMO's and their relationship with Medicare. Well, that is all well and good; they also have a parallel mission to see that they are operated in a way in which beneficiary interests are protected as this Congress said 13 years ago. They have been sorely remiss in doing that kind of aggressive monitoring. In addition to not learning from the mistakes and errors of the Florida and other demonstrations, they haven't yet remedied the plight of people hurt by those demonstrations.

In my testimony, I have listed a number of detailed recommendations for things that could be done to improve the situation, some of which the Congress people have indicated will be the subject of

legislation. I need not detail those now and I refer you to my written testimony for those matters.

Thank you.

Mr. PEPPER. How long are they? How much time would it take for you to present it?

Mr. PARKS. A while. There is a lot of problems that need to be addressed and I can summarize some of those.

Mr. PEPPER. Summarize them.

Mr. PARKS. Some relate to the situation that you described mandating a speedy enactment of people being effectively disenrolled from the HMO's. It is ridiculous that it should take from 1 to 3 months for that to happen. I agree that 2 weeks should be a minimum and that also something has to be done to resolve the situation between the time someone requests enrollment and the time they actually get disenrolled—even if it is 2 weeks—to allow for some people who just have to go to outside services in the interim.

I make a number of recommendations that the administration should see to it that an HMO's manner of processing enrollments and disenrollments, the forms it uses, the informational and marketing materials it uses are all approved and seen to be effective before they are allowed to begin enrollments. In addition, as part of that recommendation, without going into details, it is clear that many of the forms used are either extremely difficult for most beneficiaries to understand, and also facially inadequate in many respects in alerting people to what their rights are.

So I think it is important that the agency solicit the input from beneficiaries and plain-language experts as has so often been the case in some of the other notices that they use in order to see that those things are really effective, rather than the bureaucratese that is so often used.

In addition, I have a long list of suggestions in the latter part of my testimony for an ongoing monitoring program that I think the agency should implement. This would include a regular review, both of reasons for disenrollment, all incidents of out-of-plan service liability that people pick up, maintenance of hot lines for grievances and clarifying for people what the channels are that they can use to gain relief and what kind of relief they can get.

One of the things I have also mentioned in the recommendations has to do with some kind of a restriction on the card that beneficiaries have when they enroll in an HMO. It is a very sensitive area because once someone enters an HMO, if their card is restricted and what happens if they have trouble getting services from the HMO. They may then have difficulty in getting services from an outside provider when they really need it. But on the other hand, the fact that Medicare beneficiary is told that their HMO is something that is going to help their Medicare and they keep their own Medicare card is almost an open invitation to people to say, "Look, you are in the HMO, but you also have regular Medicare." It adds to this problem of people not being informed or understanding that they are in something where they are not going to be able to use their own doctor or outside providers.

So it helps make sure that people are effectively informed as to what they are getting into. It also helps them from running up outside bills inadvertently and something like that should be done,

and yet the problem, as I have said, is that it needs to be something where they can get hold of someone very quickly to allow for the situation when the HMO is not properly serving them and they need to get outside services promptly.

Those are some of the highlights of the things that I mentioned and there are many more details in the testimony.

[The prepared statement of Mr. Parks follows:]

PREPARED STATEMENT OF MICHAEL C. PARKS, ATTORNEY, NATIONAL HEALTH LAW PROGRAM, INC.

SUMMARY OF TESTIMONY

This testimony focuses on problems faced by Medicare beneficiaries enrolled in "lock-in" HMOs---those in which the beneficiary is supposed to get all services from the HMO except in emergencies. The number of such HMOs and similar organizations is expected to proliferate as a result of changes to the statute and regulations recently implemented.

With a dramatic increase in the numbers of beneficiaries enrolling in such HMOs both expected and encouraged to occur, it is important to assess whether there are problems for beneficiaries arising from this growing Medicare/HMO "partnership." It is clear that there are such problems, and that they are causing harm for large numbers of beneficiaries as well as the Medicare program.

The problems experienced by beneficiaries include: lack of adequate understanding of HMO rules and conditions (including the lock-in); uninformed and erroneous enrollments; personal liability for Medicare-coverable "out-of-plan" services; lack of information about how to remedy problems; and sluggishness of HMOs as well as HCFA in responding to complaints. Possible problems of access to and quality of care are not addressed in this testimony.

The GAO has issued a preliminary report describing problems for the government, the HMOs, and enrollees arising from the way enrollments, disenrollments and the lock-in are administered. Their study showed that 6.4% of the beneficiaries in Florida HMOs reported out-of-plan services use (other such instances may have gone unreported). It is a sobering measure of beneficiary problems and confusions---the percentage translates into some 15,000 beneficiaries nationwide.

Behind these raw statistics is a legion of confused, frustrated, angry, and often traumatized, elderly beneficiaries. This testimony includes some case studies (see pp. 2-3). For them, the embryonic Medicare/HMO partnership has been a source of bewilderment and anguish, as well as out-of-pocket cost. These experiences involve a series of experimental "demonstration" projects involving a comparatively small number of beneficiaries (over half of whom were enrolled in Florida HMOs. As the number and variety of HMOs entering the field increase, these problems and others could mushroom as well.

Over a decade ago, Congress directed the Secretary of HHS (then HEW) to monitor Medicare HMO enrollments to assure that beneficiaries were well informed and protected from abuse. The agency has failed to adequately implement such assurances, and if it fails to do so in the future, the harms already witnessed will flourish.

This testimony recommends a number of actions for the Secretary (see pp. 12-27) which would generally: require more adequately-informed enrollments; require effective implementation of beneficiary appeals processes; accelerate the time in which enrollments and disenrollments are effective; require improvements in enrollment/disenrollment processing; require steps be taken to remedy the harm already visited upon enrollees in the demonstration; and require substantial improvements in the agency's oversight functions.

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We are in a time period where the enrollment of Medicare beneficiaries in "health maintenance organizations" (HMOs) and similar plans[1] is being forcefully promoted.

Federal policy makers push HMOs as a key vehicle in Medicare cost-containment efforts. Many Medicare beneficiaries, fearful of rising health costs and the erosion of their Medicare protection, are attracted to HMO promises of more care at less cost. The HMO industry itself, and others in the health care industry seeking to become or affiliate with HMOs, actively market their product.

Policy makers expect up to 600,000 more Medicare beneficiaries to join HMOs in the next few years, spurred by recent changes in federal law. We must ask ourselves whether, despite the optimistic picture many people paint about the Medicare/HMO partnership, many victims are being left in its wake.

I believe the answer is yes. In my comments, I would like to describe some examples of this victimization, indicate some reasons why it is taking place, and suggest some remedial action that might be taken.

Let me make clear, at the outset, that I do not seek to criticize the use or growth of HMOs. I do, however, start with the

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1. Effective February 1985, entities referred to as "Competitive Medical Plans" --- which meet conditions less prescriptive than those applicable to HMOs --- are able to contract to serve beneficiaries on the same basis as HMOs. In the course of this testimony, when references are made to the future, use of the term "HMO" should be taken to include CMPs.

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assumption that the basic purpose of the Medicare program --- and the payroll and general revenue taxes which fund it --- is to provide health care coverage for its elderly beneficiaries, and not to fund any part of the health care industry.

Accordingly, I think that the effective protection of beneficiary rights and interests should be a condition precedent to the Medicare/HMO partnership.

I. SUMMARY OF PROBLEMS

This hearing was prompted by the preliminary findings in the GAO's recent Interim Report on "Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida" (March 8, 1985). That Report [hereinafter "the GAO Report"] focused on issues of enrollment/disenrollment processing and beneficiary receipt of "out-of-plan" services despite the "lock-in" features of the HMOs. My testimony is limited to problems in these same areas.

The GAO investigation was requested on account of difficulties many Medicare beneficiaries were experiencing in their relationship with Florida HMOs. Those problems are not limited to Florida. Let me share with you, for example, the plights of three Southern California beneficiaries.

> Mr. and Mrs. G, a couple residing in Mission Hills, are both in their 70s. Mr. G arranged to enroll his wife in an HMO in their area, effective last September. Mr. G says that he asked HMO representatives if his wife would be able to continue using her personal physician --- a very important consideration for them --- and was told she would be able to do so. That doctor was not, in fact, affiliated with the HMO. Learning of this, Mr. G promptly sought to disenroll his wife the same month she was enrolled, but the enrollment did not become effective for over two months. Mrs. G never used the HMO, but incurred an "out-of-plan" bill from her doctor for about $300 in the interim. Mr. G, angered by his experience, wants to wash his hands of the matter and is uninterested in pursuing the appeal process that advocates have alerted him to.

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Mrs. H, an 88-year-old widow living in Long Beach, was "enrolled" in an HMO in January 1984. She remembers being visited by a man who talked about HMOs and asked to see her Medicare card, but has no recollection of enrolling. She never used the HMO, but before being officially disenrolled [illegible] months later, she incurred some $600 in expenses for care provided by her regular doctor. Mrs. H was confused by notices received from both the HMO and the local Medicare Carrier, and was neither told of nor aware of any appeal rights. She is frustrated and aggravated by the experience, and couldn't understand why "Medicare" hasn't covered her medical bills. Her representative has contacted the HMO to question its refusal to cover her care, including by letter sent in late January, but has received no response.

Mr. S, a frail man in his 60s, lives in Culver City. He is incapable of adequately managing his affairs, and his daughter-in-law --- herself troubled with ailments --- exercices a power of attorney on his behalf. Last summer, an unsolicited mailing came to Mr. S's home, advertising an HMO. His daughter-in-law, who insists that she thought she was sending a request for further information, unknowingly submitted an enrollment application on his behalf. "Enrolled" in the HMO for a few months, Mr. S never used or visited the HMO; rather, he continued to receive services from his personal physician and incurred nearly $1,000 in "out-of-plan" services costs.

These people illustrate a series of problems increasingly coming to our attention in California. Much as in Florida and perhaps elsewhere, many Medicare beneficiaries are being enrolled in HMOs without adequate knowledge and/or understanding of enrollment conditions (such as the "lock-in" rules). As a result, many incur not only out-of-plan service costs, but may be traumatized by their experiences (as the GAO Report found) and become confused, frustrated, and disappointed with HMOs and Medicare.

Here is a list of some of the most important problems that many beneficiaries have experienced in their relations with HMOs. I will discuss them in more detail, and suggest some remedies, in Section III.

(1) Many beneficiaries enrolled in HMOs claim that they were unaware of enrolling; a frequently-heard complaint is that they thought they were signing papers to get more information.

(2) Many beneficiaries, unaware of the requirement that they receive all care from the HMO (except in emergencies), have become personally liable for Medicare-coverable services.

(3) Many beneficiaries, unaware of the considerable length of time between their requests to disenroll and the effective date of the disenrollments, become personally liable for Medicare-coverable services in the interim.

(4) Most beneficiary advocates, let alone beneficiaries, are unaware of appeal rights they have to redress these problems. This is because information about these rights is not adequately made available and because the rights are not enforced.

(5) Beneficiary representatives complain that HMOs (and HCFA) take an inordinate amount of time to respond to beneficiary claims.

(6) There is a broad problem of inadequate information for beneficiaries: beneficiaries don't receive all the information that is due to them; there is advertising overkill; many important coverage issues are inadequately explained; information is not provided in languages other than English where such is appropriate.

I believe a substantial part of the reasons for these problems is that the Health Care Financing Administration has failed to adequately implement beneficiary protections which Congress envisioned and which the agency's (and its predecessor's) own regulations call for. I have spoken with many agency representatives who are deeply concerned over beneficiary problems and who are eager to work for their resolution. As a general rule, however, I believe the agency has devoted most of its energy and attention to the growth of Medicare HMOs and not enough to the kinds of problems discussed here.

The kinds of problems discussed in this testimony have been known to agency officials for at least 3-5 years and perhaps longer. Because they have affected only the small portion of

beneficiaries who have enrolled in lock-in HMOs, and because of the difficulty faced by affected beneficiaries in understanding and asserting their rights, these problems have been slow in gaining public attention. Their actual dimensions will become clearer as more attention is focused on them, and --- unless steps are taken --- they will grow along with the growth of the Medicare/HMO "partnership."

II. BACKGROUND

A. Background --- The Witness

My own study of this and other Medicare issues arises out of two general functions I perform. I have been a staff attorney at the National Health Law Program (NHeLP), specializing in part in Medicare, for 5 1/2 years. NHeLP is a legal services support center which provides advice, training, information, and analytical materials to legal workers throughout the country.

As a result of this work, I began studying Medicare/HMO issues in mid-1984 and have had extensive contact with beneficiary representatives in Florida. In Los Angeles, where my office is located, I am a co-founder of a community-based organization called the Medicare Advocacy Project (MAP). MAP represents and counsels a large number of individuals and groups about their Medicare problems, and I've continued to have extensive contact with the program's work.

In the course of these contacts, I have become aware of problems that many individual Medicare beneficiaries have had with HMO participation. In addition, through personal conversations, study of materials, and attendance at meetings, I've had a considerable amount of contact with federal officials administering Medicare/HMO matters.

B. Background --- "Lock-In" HMOs

Medicare has authorized reimbursements to organized health systems since the inception of the program, before the term "health maintenance organization" was even known.

In 1972, however, 42 U.S.C. 1395mm (§1876 of The Social Security Act) was added to the Medicare Act, and specifically authorized reimbursement to "HMOs." A critical component of this law was the authorization for HMOs to operate on an "at risk" reimbursement basis, under which enrolled beneficiaries would be "locked-in," i.e., required to receive almost all health care services from the HMO.

Such HMOs, which I shall refer to in this testimony as "lock-in HMOs," are the focus of our comments today. This is because in other HMOs, the beneficiary may essentially receive services anywhere, and receive Medicare coverage from them. Beneficiaries inadequately informed about these other HMOs may lose some of the purported advantages of the organizations, but will not suffer the harms noted herein.

Only one of the nearly 65 HMOs that entered into a Medicare contract under the 1972 law became a lock-in HMO. However, several organizations in different parts of the country operated as lock-in HMOs under experimental "demonstration projects" in the first years of this decade. It is from these experimental projects that most of our information about the problems discussed herein are known. Amendments to the Medicare HMO law and regulations designed to promote more lock-in HMOs were implemented only recently.

C. Background --- Legislative History

When §1876 was adopted in 1972, Congress was expressly interested in making certain perceived advantages of HMOs available to the Medicare population. But Congress also recognized that HMOs might create problems for beneficiaries.

The Senate, whose version of the Bill was essentially adopted, was forceful in its comments about the need for beneficiary protections. Its Report stated:

> "The purpose of this amendment is solely to establish a mechanism for determining which HMO's are acceptable for incentive [i.e., Lock-in] reimbursement under Medicare. It is an amendment intended to protect beneficiaries and public trust funds...." (emphasis added)

The Report asserted that the amendments were designed to "reasonably safeguard" the interests of the Medicare program and beneficiaries.[2]

Both the House[3] and the Senate Reports on the provision underscored their expectation that the Secretary of HEW [now HHS] would effectively implement an "ongoing" review program to assure that HMOs effectively fulfilled beneficiary service needs. This program would have to assure, among other things, that beneficiaries were fully informed about subjects like the lock-in, and that HMOs did not use any devices to discourage or deny care.

The law as adopted included several beneficiary protections. One of these was an important provision relating to "out- of-plan" service use. Congress provided that an appeals process had to be established under which beneficiaries could compel reimbursement for

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2. See, generally, Sen. Rep. (Finance Committee) No. 92-1230, Sept. 26, 1972 [to accompany H.R. 1].

3. See, generally, H. Rep. (Ways & Means Committee No. 92-231, May 6, 1971 [to accompany H.R. 1].

such services if they were emergency services, "urgently needed" services, or services "which should have been furnished by...[the HMO] but...not made reasonably available."[4]

As already noted, only one HMO in the country sought a lock-in Medicare contract under the 1972 law. However, prior to the amendments adopted in the Tax Equity & Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, §114, which authorized the new Medicare/HMO rules, other developments of note were taking place regarding HMOs.

In 1973-74, news of a scandal arose from California, where a major attempt to blend lock-in HMOs and public funding had taken place. California attempted to promote extensive enrollment of Medicaid beneficiaries in HMOs, a/k/a prepaid health plans. The results had been calamitous.

As summarized in a 1978 Report of the Senate Permanent Subcommittee on Investigations entitled "Prepaid Health Plans and Health Maintenance Organizations," Rep. No. 95-749 (April 20, 1978), problems revealed in the California initiative included: (a) beneficiaries being misled, and sometimes coerced by aggressive salespeople, into enrolling in plans; and (b) extreme difficulties encountered by beneficiaries seeking to disenroll. (In addition, many plans had been making it difficult to obtain services, and seeking to encourage disenrollment of "sicker" patients.)

The Report found that "Perhaps the greatest number of abuses

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4. This latter basis for appeal is unfamiliar even to most advocates who have worked with beneficiaries, and is poorly publicized by HCFA. Even the GAO Report, which mentions it late in the text (p. 27), excludes reference to it throughout most of the Report by continually stating that neither Medicare nor the HMO can cover out-of-plan services that are not emergency or urgently-needed services.

found by the Subcommittee involved marketing and enrollment abuses" (p. 13). The Committee concluded that both the federal and the state agencies had failed to exercise adequate oversight:[5] "...[F]rom the time the program began through the period of greatest abuse --- DHEW officials did little to protect the Federal interest in the plans" (p. 29).

In the Health Maintenance Organization Amendments of 1976, P.L. 94-460, Congress adopted a number of amendments to various HMO provisions. Largely in response to the California scandals, the Medicaid Act was amended to limit the kinds of HMOs that could serve Medicaid beneficiaries under lock-in arrangements. The amendment required such HMOs to incorporate the beneficiary protections required for federally-qualified HMOs. The Conference report notes that it supported such changes "because of the need for increased Federal oversight of arrangements under [Medicaid]...for services provided on a prepaid risk basis."[6]

Congress and the federal agency early on recognized that HMO enrollees who were beneficiaries of public programs might be more readily victimized than privately-insured enrollees. Federal law has long included a waivable requirement that no more than half of an HMO's enrollees can be Medicare or Medicaid eligibles. The 1976 amendments added a requirement that HMOs establish arrangements under which an enrollee's source of payment would not be known. The

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5. Coincidentally, it was a study and report by the GAO which was one of the developments bringing the scandal to Congressional attention. See "Better Controls Needed for Health Maintenance Organizations Under Medicaid in California," (GAO, Sept. 13, 1974).

6. See H. Rep. (Conference Committee) No. 94-1513 [to accompany H.R. 9019].

Conferees stated that this assisted in assuring equitable treatment.[7]

When the Medicare/HMO provisions in TEFRA were adopted, most of the comments in the Congressional Reports addressed the new reimbursement and organizational changes. But many beneficiary protections were in fact reenforced in the language of the Act, and Congress did nothing to erase the concerns it first raised at least 13 years ago.

D. Background --- The Medicare/HMO Lock-In Experience

Despite the authority for lock-in contracts enacted in 1972 --- and perhaps due to the beneficiary protections built into that provision --- only one HMO entered into a lock-in contract. As a result, most evidence concerning the experiences of publicly-funded beneficiaries in such situations during the 1970s came out of Medicaid involvements such as the California scandals.

In 1980, however, in order to test the viability of the Medicare/HMO provisions that would ultimately be adopted in TEFRA, the Department of HHS launched an experimental "HMO Capitation Project." The project involved 8 established HMOs in 5 communities. At the time, the 63 existing §1876 HMOs had 110,000 Medicare enrollees. The demonstration HMOs enrolled between 1,200 and 9,000 beneficiaries each.

In 1982, DHHS launched a more ambitious experiment, called the "National Medicare Competition Project." The GAO Report focuses on HMOs involved in this second round of demonstration experiments. At the time this second round began enrollments, HCFA had already accumulated two years' worth of experience from the earlier experiment.

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7. See H. Rep. (Conference Committee) No. 94-1513 [to accompany H.R. 9019].

The 1982 demonstration program authorized contracts with 28 HMOs, but most began operations, if at all, only in the past year, and the enrollments in most were small. A handful of plans in Florida began operations in 1982 and, as a result of this head start and the unusually rapid membership growth of one --- International Medical Centers, Inc. --- had enrolled, by late 1984, about one-half of the more than 220,000 lock-in enrollees nationwide. As of mid-1984, they accounted for about two-thirds of all lock-in beneficiaries. In California and elsewhere, enrollment has been much lower, more recent, and more slowly paced. Thus, the majority of evidence about Medicare beneficiaries in Lock-in HMOs comes from the Florida experience.

III. DISCUSSION AND RECOMMENDATIONS

The GAO Report focuses primarily on the administrative problems associated with enrollments, disenrollments, and the lock-in. The Report does provide valuable information and ideas about the resultant problems caused for beneficiaries; this testimony focuses almost exclusively on the problems as they impact upon beneficiaries.

The human dimension to these problems must be kept firmly in mind. The GAO Report, discussing the 6.4% of enrolled beneficiaries who reported out-of-plan services use, observed that some of the claims were (often erroneously) eventually reimbursed and that the beneficiaries paid only a small portion. Beneficiaries are, however, billed for all these amounts by the outside providers and, in our experience, many of these claims eventually go to collection agencies. The anguish and the confusion which exist in these situations is something nobody who works with elderly clients would ever minimize.

The GAO Report recognizes that some claims may never have been reported. On the other hand, it also suggests that HCFA, the Carriers, Intermediaries, and HMOs will be reviewing claims "erroneously" paid. Will these reviews result in more personal liability and personal trauma for beneficiaries? What will be done to prevent that?

Except as qualified below, we endorse the recommendations made by the GAO. The recommendations which follow represent our best judgment at this time as to steps that should be taken to ameliorate the problems described today and to assure that they do not recur. Several address the need for improvements in the marketing and enrollment process, subjects which the GAO has deferred to later reports. We think, however, that those subjects are important to the problems discussed today.

A. Marketing and Enrollment

If HMOs are to compete for Medicare business legitimately and on their merits, Medicare beneficiaries should be making well-informed decisions about enrollment. While most competition theorists would agree with this in general, it is particularly important with the HMO concept, which is not fully familiar to potential enrollees.

Information about certain matters --- such as the nature of lock-in, effective dates of coverage, and where and how to obtain services --- is particularly important because of the consequences for personal liability and quality of care inherent in those subjects.

Congress, as noted, was from the outset concerned that enrollees be "fully informed." The Department's own regulations

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have always required HMOs to provide potential enrollees with written descriptions of coverage rules and limitations sufficient to allow beneficiaries to make an "informed decision" about whether to enroll. See 42 C.F.R. 417.223(c); 42 C.F.R. 417.428(a).[8]

Similarly, federal law has continuously forbidden marketing practices that could mislead or confuse potential enrollees; see, e.g., 42 C.F.R. 417.223(d), 417.428(b). As earlier noted, inadequately informed enrollments were a major element of the California prepaid health plan scandals of the early 1970s.

Despite these concerns, there is little doubt that many beneficiaries, to their financial peril, are enrolled in HMOs without adequate knowledge. Such problem enrollments seem to take various forms. Several beneficiaries claim they did not know that papers they signed were actually enrollment forms. Others are aware of having signed up with an organization, but insist that they were unaware of some of these vital rules.

There are many reasons why this problem exists. Some HMO marketing representatives obtain enrollment applications from people during initial contacts --- (formerly) at the beneficiaries' homes, and in various community sites such as senior and nutritional centers, apartment meeting rooms, and even cheese lines. Some beneficiaries enroll by mail, perhaps in response to media advertisements. Without addressing the issue of improper marketing, suffice it to say that these encounters do not stress potential problems beneficiaries may face.

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8. Where two regulatory cites are given as above, the first refers to the provision in the "old" regulations and the second refers to the applicable provision in the recently-enacted regulations.

Beneficiary representatives report considerable confusion among the elderly as to the HMO rules and conditions. It's easy to see why this is the case. Medicare beneficiaries --- worried over health coverage --- are subjected to a blitz of advertisements about all kinds of plans to "supplement" or "extend" their Medicare coverage. HMOs are commonly marketed in this manner, under names like "Golden Plus," "Eldercare," or "Senior 65." I myself am frequently unable to understand what kind of plan some advertisement is offering. The beneficiary can "enroll" in an HMO by signing a slip of paper,[9] without having to visit the HMO, without paying anything, and s/he keeps his/her Medicare card.

Some elderly beneficiaries have difficulty in understanding the terms and conditions, and some --- according to some industry and agency observers --- simply forget them during the lengthy time period between the time they sign enrollment forms and the time their enrollments are effective.

How widespread is the problem? The GAO's Interim Report on the Florida demonstration projects found that about 6.4% of the beneficiaries examined (over 9% in one plan) received out-of-plan services --- one valuable indicator of lack of understanding of the lock-in. At a HCFA Conference on HMOs I attended last December in San Francisco, representatives from both HCFA and West Coast HMOs reported lock-in misunderstanding as a significant problem. While out-of-plan service use is an indicator of the dimensions of the problem, some beneficiaries may not claim these expenses, and others

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9. With that simple stroke of the pen, thousands of federal dollars will begin flowing to the HMO, and the beneficiary places him/herself at risk of the problems discussed today.

may disenroll prior to becoming such a statistic.

The GAO Report states that "most" or "the majority of" enrollees understand the lock-in restriction. Assuming that is, in fact, the case, this nonetheless means that a proportionally small but numerically large number of enrollees don't. If we assume the number of inadequately informed beneficiaries to be only the 6.4% identified by the GAO, that would mean that there are over 15,000 such people today --- a number that will triple if HCFA's projections of HMO enrollment growth come true. I think it's reasonable to conclude that these figures more accurately reflect the numbers of people that may potentially incur the trauma of out-of-plan liability, and that the number of people who become inadequately-informed enrollees is much larger.

Federal law and policy had long recognized the need to regulate the HMO marketing and enrollment process. The adoption in the new regulations of a ban on door-to-door solicitation, 42 C.F.R. 417.428(b)(4), is only one of the latest expressions of understanding that beneficiaries need protection in this area. In order to properly effectuate this process, I recommend the following steps be considered:

(1) HCFA should establish improved, minimum standards for written marketing and membership materials. HCFA already possesses this authority. The agency should promptly consult with beneficiary representatives and language experts to determine how to make explanations of problem areas like the lock-in, disenrollment, and services access more prominent.

(2) HCFA should reestablish the requirement that written marketing and informational material be approved in advance. This practice, entrenched for years under the old law, was deleted in the new regulations. This was done in response to criticisms by the FTC and others that the provision deterred legitimate communications in overbroad fashion. A reasonable compromise would be to retain the requirement for the standard informational and membership rule materials that the law

requires, while removing it, pending continued study, from random media advertisements.

(3) HCFA should require that marketing and other informational material be available in languages other than English where an applicant or member's primary language is other than English. Where the HMO's community includes an eligible population of which 5% or more has a primary language other than English, such translated material should be mandatory. They should also be mandatory for any such person who actually applies for enrollment.

(4) HCFA should adopt regulations providing that where any marketing material or advertisement is found to have violated the proscribed activities regulations, any beneficiary enrolling in response to it may retroactively disenroll. The state of Florida, for example, adopted a provision, effective December 31, 1984, that authorizes analagous relief. Under Florida Statutes §641.385, HMOs found to have engaged in improper advertising can be directed to provide each applicant with clarified information before accepting applications.

(5) HCFA should require HMOs to provide new enrollees with membership rules within a fixed time relative to the effective date of their enrollments. Federal regulations have consistently required HMOs to furnish written membership rules to "enrollees," 42 C.F.R. 417.224(b); 417.436(b). The regulations do not say when (or how) this should be done. Many beneficiaries claim to have never received such rules. Our recommendation is that HCFA require that they be provided to enrollees within a short time period --- perhaps one week --- of the effective date of their enrollment.

Part of the reason for this timing relates to our comments about information at the time of initial enrollment.

(6) HCFA should prohibit HMOs from enrolling beneficiaries coincidentally with an applicant's initial receipt of information. Federal law has always provided that Medicare HMO applicants should be provided with adequate information, in writing, to enable them to make "informed" decisions as to enrollment. This is facially inconsistent with an on-the-spot enrollment or an enrollment solely by mail contact, and certainly inconsistent with the needs of the vulnerable elderly for adequate information. We recommend that an individual's application should not be accepted until the applicant visits the HMO. Some demonstration HMOs use phone follow-ups, a practice which is hard to monitor and which has been proven to be far less effective in informing beneficiaries than a site visit.

(7) HCFA should intensify scrutiny of HMO marketing practices to better identify and regulate abuses. Misleading practices have been cited in HMO marketing for years. As marketing efforts continue to intensify, they have not gone away. On

the contrary, newer and different questionable practices are continually uncovered. HCFA should both increase its own monitoring and publicize channels through which consumers can raise complaints.

B. Beneficiary Appeals

Probably the most important remedy available to beneficiaries who incur out-of-plan medical costs is an appeal process that has been part of the law since the 1972 Act. See, e.g., 42 U.S.C. 1395 mm(f) (1972), 42 U.S.C. 1395mm(c)(5)(B). Under this process, beneficiaries are able to compel the HMO to pay the costs of their out-of-plan services if such services were emergency or urgently needed services or ones for which the HMO should have been responsible. The Administrator of HCFA Region IX advised me that beneficiaries can use this process to recover costs arising from their inadequate knowledge of the lock-in, though this fact has not been published.

HCFA has maintained regulations detailing this appeal process for nearly a decade; see 42 C.F.R. 417.256 et seq.; 417.600 et seq. When a beneficiary is recorded as being enrolled in an HMO, reimbursement requests for out-of-plan services will be rejected by the Medicare Carrier (or Intermediary, as the case may be). The Carrier sends the claim to the HMO, and sends a notice to the beneficiary stating that the claim has been denied by virtue of HMO enrollment. Many clients report that they first become aware of having violated an HMO lock-in when they receive this notice. [The GAO Report noted that the admimistration of this process is rife with errors].

The federal regulations describing the appeals process notes that HMOs must make a determination as to whether such claims are coverable, notify the beneficiary (within 60 days of the "enrollee's request for payment") of its determination, detail the reasons for

the determination, and inform the beneficiary of his/her further appeal rights.[10] The regulations require HMOs to "ensure" that beneficiary enrollees are informed in writing about the appeal process. See 42 C.F.R. 417.257(d); 417.605(c).

Thus, the law provides a potentially valuable source of protection for beneficiaries. Unfortunately, it is essentially non-existent. Beneficiaries are not apprised of it, the HMOs I have looked at have not implemented it, and HCFA has generally failed to monitor it. I and other advocates discovered it only through arcane research. Despite a high incidence of complaints of all kinds, including out-of-plan services expenses, no appeals had been filed in Florida over a two-year period and only two or three in the Western region. Nobody knew of these rights; they were not enforced.

My inquiry regarding several Medicare HMOs in Florida and California showed that each sent "determination" notices on out-of-plan claims that were skeletal checklists and which made no reference to any appeals rights. There is no evidence of any reasoned determination; certainly, no reasons are detailed. In fact, one Los Angeles-area HMO, when contacted by one of my colleagues about such a determination letter, flatly stated that any future out-of-plan services claims would also be rejected. This despite the fact, for example, that bone fide out-of-plan emergency services should clearly be covered.

In order to infuse the important appeals process with the

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10. These include a request for "reconsideration" by the HMO --- which is reviewed and subject to modification by HCFA --- and subsequent appeals to a Social Security Administrative Law Judge and the judiciary (there are minimum amounts in controversy conditions).

minimal teeth it should have, we recommend the following:

(1) HCFA should mandate improvements in the Carrier/Intermediary notices of non-coverage to more adequately inform beneficiaries. The notice should apprise the beneficiary of his/her "HMO appeal" rights and indicate how an appeal is initiated. The notice should also advise the beneficiary that information about HMO enrollment and the appeal rights can be obtained by calling a toll-free number.

(2) HCFA should promptly assure that the determination notices (and reconsideration determinations) used by the HMOs are legally sufficient. HCFA should enforce its own requirements that the notices detail the reasons for denials, and advise beneficiaries of continued appeal rights. In addition, the agency has frequently been directed by the courts to implement adequate notices of Medicare and other public program benefit decisions, and such principles plainly apply here as well.

(3) HCFA should clarify and streamline the appeals process to improve its effectiveness. Beneficiary advocates seeking to use the appeals process recently have experienced some confusion. The language of the regulations, as noted above, suggests that the determination duty is triggered by an enrollee's request for payment. This provision fails to take into account that most beneficiaries don't know of their rights, and that it is the Carrier's notice to the HMO (and beneficiary) which usually triggers (though not always) the HMO's initial determination. The regulations should be amended to provide that the determination should be made in response to an enrollee's request or a Carrier's notice, whichever is earlier. In addition, we would suggest a shortening of the time within which determinations should be made to 30 days, rather than 60 days.

(4) HCFA should clarify the range of relief it can provide through the process. HCFA representatives have indicated that this process is the vehicle beneficiaries should use to allege an uninformed enrollment. This fact, and the varying kinds of relief available, should be stated more clearly --- even if only in general terms --- in writing.

C. Disenrollment

A central finding of the GAO REport was that the inordinate length of time between a beneficiary's request for disenrollment and the effective date of that disenrollment is a significant source of harm for beneficiaries. Once they have taken the step to disenroll, they're obviously reluctant and unlikely to use the HMO's services. Through confusion and/or medical need, they will often incur "out-

of-plan" costs which Medicare will not pay. This has, the Report found, resulted in substantial personal expenses, and trauma for many beneficiaries. Also noted was the potential cost to the Medicare program --- any beneficiary who is improperly enrolled in an HMO and promptly disenrolls can be officially enrolled for 3-4 months and more at a cost of $700-$1,000 to the Medicare program.

The original Medicare/HMO provision did not set time limits for disenrollment processing, but HCFA's regulations required the beneficiary's request to be made at least 30 days before the month of disenrollment. See 42 C.F.R. 417.227(b). In the TEFRA amendment, for reasons this witness could not ascertain, the statute concretized this standard. 42 U.S.C. 1395mm(c)(3)(B) provides that a beneficiary may disenroll "as of" the beginning of the second calendar month after the month the request is made.

The rationales for this provision, though not perfectly clear, appear anachronistic. Some observers claim that the lengthy period is prompted by the Social Security data processing system --- commonly recognized as antiquated --- through which HMO enrollments and disenrollments are processed and recorded. Be that as it may, the state of the art in data processing now allows for much speedier processing. In fact, in the past year, HCFA has entered into an arrangement with a private company called "Compuserve," which is able to process and report enrollments and disenrollments (a/k/a "accretions" and "deletions") within 15 days, and reportedly with an error rate only a tenth of that experienced in the current system.

HCFA's regulation interprets 42 U.S.C. 1395mm(c)(3)(B) to establish a minimally-required waiting period; see 42 C.F.R. 417.469 (b)(1). The agency has taken the position, in its discussion of the

new regulations, that the statute requires this; see 50 Fed. Reg. 1325 (January 10, 1985). This is a credible position; however, I do not think it is unequivocally required by the statutory language and intent.

The enrollment/disenrollment implementation periods should be shortened appreciably. The GAO Report shows, however, that some beneficiaries incur out-of-plan services within a week, or even a day, of the time they complete their disenrollment form (p. 26). As the GAO noted, something must be done to remedy their plight as well. We offer the following recommendations:

(1) HCFA should amend its regulations to require that disenrollments be effective promptly, by at least the first of the month for requests made up to the 20th day of the previous month, and faster, if possible. Absent compelling reasons to the contrary, the term "as of" in the statute could be interpreted to establish an outside time limit which can be shortened. The time period should be as short as reasonably, technically, and administratively possible, and should, if feasible, authorize effective dates other than the first of the month.

(2) If need be, Congress should adopt a technical amendment authorizing or mandating a shorter time period.

(3) HCFA should require that HMOs give beneficiaries a copy of their disenrollment request form. Such a requirement would help resolve disputes as to whether and when such requests are made. It would also facilitate the remedy proposed by the GAO Report to alleviate the problem of out-of-plan service coverage during the disenrollment period.

(4) HCFA should adopt a system under which beneficiaries are assured covarage for medically necessary services obtained during the period before a disenrollment becomes effective. We agree with the GAO that Medicare coverage during this period must be assured, but we do not at this time offer a specific recommendedation as to how coverage responsibility should be allocated or enforced.

D. Improving Enrollment

Much of the ability of beneficiaries to incur non-reimbursed out-of-plan services turns on the fact that enrollees' Medicare cards do not have to be "restricted" coincidental with HMO enroll-

ment. Any beneficiary who does not fully understand the "lock-in" requirement and who retains the same card s/he has used and/or known of for years is a likely candidate for out-of-plan use. Use of a restricted card would establish and reenforce the fact of enrollment, and alert out-of-plan providers to the enrollment status.

Although HCFA has recently permited and, in some instances, encouraged the use of card restrictions, it does not require them. Indeed, agency officials had been traditionally opposed to such requirements.

The reasons which have been communicated to me by HCFA officials for this policy are as follows: 1) Disinclination to have "ironclad" rules; 2) The fact that many beneficiaries don't have their cards available when they enroll; 3) Complaints received from public officials on behalf of beneficiaries opposed to the idea; and 4) Psychological dependency of many beneficiaries on the card. I believe that all but the last of these lack merit.

If a rule is necessary, important, and sensible, it should be required; HMOs, like everyone else in life, must follow several "ironclad" rules. I think most complainants would understand the reasons for rules such as this. Regarding the unavailability of the Medicare card, it seems astonishing that enrollments under such circumstances are allowable. Misinformation about enrollees' Medicare claim numbers is the most common reason for the high error rate (10%) in enrollment/ disenrollment processing. Such a practice surely contributes to those enrollees' misunderstandings about HMOs.

There is credibility to the contention that many beneficiaries are "psychologically" or otherwise reluctant to "give up" their Medicare cards. The fact is, however, that these same beneficiaries

are the ones most likely to misunderstand or oppose the lock-in aspect of an HMO. They are the very people who most need to be adequately informed of HMO rules and conditions. Use of a restricted card for their education and protection is likely to be more helpful for them than anyone else.

"Restricting" the Medicare card does not have to mean taking it away and replacing it (although this is done, for example, by Medicaid and some commercial insurers). The Fallon Community Health Plan in Worcester, Massachusetts (the first of the Medicare demonstrations), in order to address problems of beneficiary misunderstanding, early on adopted the practice of using clear plastic holders in which both the HMO card and the Medicare card are placed. At least one demonstration HMO representative has advised HCFA "many times" that such card restrictions would be helpful.

At least three potential problems might exist regarding card restrictions: there may be difficulties in assuring that the restriction is actually made coincident with the effective date of enrollment; there may be similar difficulty regarding disenrollment; and enrollees who are improperly denied HMO care may have greater difficulty obtaining needed services out-of-plan. While I am unaware of these problems arising at Fallon, for example, they would require further study and monitoring.

These potential problems will be substantially alleviated by the acceleration of enrollment/disenrollment processing. As to disenrollments, the restriction could be lifted at the time the disenrollment form is filled out and/or a disenrollment date noted. As to enrollments, HMOs should be required to assure that the restriction is implemented in a timely fashion.

We recommend that the following steps be taken:

(1) HCFA should require each HMO to implement a system whereby each beneficiary's Medicare card is restricted during the beneficiary's enrollment period. While the Fallon approach appears to be the one which best accommodates the conflicting concerns underlying this issue, it is probably premature to direct any specific methodology.

(2) HCFA should require each HMO to implement a system whereby the card restrictions are implemented coincidental with the effective date of enrollment. The HMOs could, for example, be held presumptively responsible for any services incurred prior to the date of the restriction.

(3) HCFA should require each HMO to include with beneficiary identification cards instructions for "outside providers" on services and claims processing, and to notify each hospital in its area, in writing, of these issues.

E. DHHS Oversight

In my study of the Medicare/HMO partnership, I've seen little evidence of concerted DHHS response to the problems noted in this testimony and the GAO Report. These problems have persisted for several years. Problems of beneficiary misunderstandings and lock-in violations were well known at least as early as 1980, from the experience of the Fallon demonstration. At the HCFA-sponsored conference I attended last December, representative after representative of HMOs stated that these were known to be among the biggest problems in HMO administration.

Yet what sweeping actions has HCFA taken? What actions has the agency taken to make whole the beneficiaries hurt in its experiments? None that I'm aware of. Can the agency be said to have effectively implemented the protections Congress "expected" years ago? What did it do in the two years between the first and the second rounds of experimental demonstration projects to act on the lessons learned?

I am unaware of HCFA's ever having done an oversight investigation remotely resembling that done by the GAO. I am unaware of the agency's having taken taken any comprehensive action to remedy the harm that enrolled beneficiaries have experienced. HCFA has funded studies of the demonstrations, but these are multi-year and analytical in nature. They do nothing to implement reforms or to help the many thousands of beneficiaries victimized in the interim.

The agency has taken many steps for which it should receive credit: for example, funding the AARP's "Informed Buyer" educational project; requiring, despite its own long-standing opposition, some use of card restrictions in South Florida; and halting the use of one HMO's particularly misleading application card. Some agency representatives will doubtless mention or allude to other actions. The members of this Subcommittee must ask themselves whether such actions are adequate, considering the resources the agency has at its disposal and the gravity of the matters at stake. I think you will agree that the answer is no.

The agency's primary focus has been to promote the growth of Medicare HMOs. Attention to forceful implementation of beneficiary protections has been a back-burner issue.[11] It is high time for that emphasis to be reversed. Congress has amended the law to give the industry the financial incentives it said it needed. It is now

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11. Note, for example, that HCFA has failed to adequately implement and enforce beneficiary appeal rights (see Section III.B., supra). The agency is cognizant of the fact that, despite highly-publicized problems in the South Florida HMOs --- including over 7,000 out-of-plan services incidents --- no beneficiary appeals were ever filed (see GAO Report, p. 27). Some individuals, fortunate enough to have their cases come to the attention of a legislative aide or be sensationalized in the media, were able --- after inordinate waiting --- to have their problems remedied.

long past the time when the beneficiary protections Congress has recognized as critical since 1972 should be guaranteed.

(1) HCFA should promptly arrange for review of all claims for out-of-plan services incurred by enrollees of the demonstrations to assure that the beneficiaries are held harmless. All those beneficiaries were the subjects of a governmental experiment. The agency should be sure that it has adequately learned the lessons of its experiment, but at the same time, the subjects should not bear the burdens of the problems demonstrated. If processing of appeals for the affected beneficiaries is too great an administrative burden, their claims should be reimbursed by Medicare and/or the HMO.

(2) HCFA should promptly arrange for a study of beneficiaries who disenrolled from the HMOs and/or used non-emergency out-of-plan services, to assess the reasons. Such a study must involve in-person contact. The reasons for disenrollment written on forms have been shown to potentially mask the real reasons.

(3) HCFA must improve its contract approval process to better assure that the HMO's informational materials, notices, and enrollment/disenrollment processing are adequate before beneficiaries can be enrolled.

(4) HCFA should establish and implement an improved system for the monitoring of HMO problems. Such "ongoing" monitoring by the agency was first called for by this Congress in 1972. The problems discussed here may persist or recur, and others may arise, as the HMO/Medicare partnership forges ahead. The monitoring system, which will serve to monitor other kinds of HMO problems as well, should consist of several components, such as:

(a) Periodic study of the reasons for disenrollment and out-of-plan service use, as noted in #2.

(b) Required submission by HMOs of monthly or quarterly reports of grievance filings and resolutions. These should be studied and, possibly, made available for public inspection. This approach presumes that the required grievance procedures are adequately implemented, something which --- though behond the scope of this testimony --- is subject to doubt.

(c) Use of a publicized, toll-free number to record complaints (as well as to advise callers about the channels to remedy their complaints). Referring such persons to local Social Security offices is inadequate.

(d) Use of improved beneficiary satisfaction studies. Such studies should not, among other things, be limited to enrollees who use the HMO facilities.

(e) Possibly the use of an Ombudsman.

(5) The agency must published a detailed, accurate statement which describes the avenues available to enrollees questioning HMO conduct, the remedies available under each, and the personnel responsible for each.

(6) The Department of HHS must assure that its personnel who deal with the public are aware of the information referred to in #5 or know where to refer people. Our contacts with some HCFA officials, let alone workers in Social Security offices, have shown that this is clearly not happening now.

(7) HCFA should refuse any further waivers of the "50% rule" except where the HMO's service area population is over 50% Medicare and Medicaid eligibles.

IV. CONCLUSION

Many public officials, policy analysts, industry representatives, and consumers envision a day when vast numbers of Medicare beneficiaries will be enrolled in HMOs. As we move toward that day, are we sure we're ready to address the problems that real people will experience? An experiment involving only a small percentage of beneficiaries, and in most cases involving established HMOs, gives us ample reason for doubt. What will happen as the numbers of enrollees mushroom, as HMOs that are less well-established, perhaps less well-motivated, enter the field?

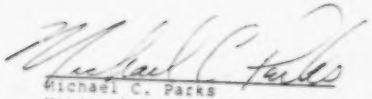
If we do not prepare adequately for that time, we will surely be sitting one day in a hearing room like this, decrying damage in lives and public dollars.

The problems addressed in this hearing, despite their seriousness, do not purport to canvass all the problems that we may legitimately fear in Medicare/HMO proliferation. Potential problems of access to services and quality of care have been experienced and predicted for years, and will demand monitoring and attention as well. Nevertheless, we must move to remedy the problems discussed today.

The time to launch concerted action on these matters, having already passed, must commence apace. Some remedies of the sort discussed herein can and should be implemented at once; others have multi-faceted consequences and require additional analysis and input. While steps must be taken to avoid future harm, something must be done to remedy the situation of enrollees who have already been hurt.

I am certain that concerned beneficiaries, their organizations, and advocates* will want to participate in --- and should be consulted regarding --- steps taken to make the Medicare/HMO partnership more effective. Those steps, and that involvement, should be taken before the partnership becomes another "broken promise."

Respectfully submitted,



Michael C. Parks
National Health Law Program

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* Among the advocates with whom I have worked in examining these problems are Cindy Huddleston (a witness today) and her colleagues at Legal Services of Greater Miami, Barbara Prager of the Senior Citizens Law Project in Ft. Lauderdale, and Bess Brewer and Aileen Harper of the Medicare Advocacy Project in Los Angeles. They and many other advocates are working hard to vindicate the rights and interests of beneficiaries under Medicare and related health coverage plans.

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Mr. PEPPER. Thank you very much, Mr. Parks, for your good statement.

Ms. Sposa, we would be pleased to hear from you.

STATEMENT OF HELEN SPOSA

Ms. SPOSA. Mr. Chairman, and members of the committee, my name is Helen Sposa. I am from Plantation, FL. I am here today to speak about my in-laws, Helen W. and Louis A. Sposa, of Fort Lauderdale, who chose to join a health maintenance organization in November 1982. At this time, their ages were 68 and 71.

My father-in-law was in good health; my mother-in-law has high blood pressure and an occasional skin melonoma. They were told they could use many hospitals in the Fort Lauderdale area, receive free eyeglasses and free hearing aids if needed.

When my father-in-law needed glasses, he received the free ones. They lasted approximately 1 week before the frames broke. My mother-in-law needed a hearing aid. When shown the free one, it was a large bulky one which is outdated. She refused the free hearing aid.

In June of 1983, my father-in-law began to have muscle weakness in his shoulders and occasional double vision. For several months, he underwent tests resulting in no diagnosis. He then, and only then, learned that the only hospital he could use was 15 miles from his home. He was admitted to this hospital.

During his stay, he was diagnosed with myasthenia gravis and placed on medication for control. One evening several months later, he began to hyperventilate. My mother-in-law drove him this 15 miles to the HMO hospital since no other hospital would take him. During this frightening trip, he rode most of the way with his head hanging out the car window, gasping for air.

My mother-in-law told me she was terrified and thought he would die before she could reach the hospital. His medication dosage was changed and he was fine. During this hospital stay, his assigned doctor told him: "Mr. Sposa, your problem is all in your mind."

My father-in-law said he would die at home before he would ever go back to that hospital or that doctor. May 7, 1984, he again experienced hyperventilation. This time, my mother-in-law and her neighbor took him to a Fort Lauderdale hospital and insisted he be admitted. Efforts to adjust his medication were futile. He was placed on a respirator and a tracheotomy was attempted.

Four days later, his assigned doctor ordered his transfer to Jackson Memorial in Miami for a blood-washing procedure called plasmapheresis. The HMO refused to move him, saying the procedure was not approved by Medicare.

I immediately telephoned Blue Cross, Jacksonville, and was told the procedure was approved. When I told the HMO representative this, he replied: "We still will not approve the transfer and besides that, Mrs. Sposa, Jackson wants nothing to do with HMOs."

From May 11 through May 17, we were back and forth between doctors and the HMO in an effort to get him transferred. During this time, my father-in-law continued to deteriorate. On May 17, we went to see the HMO representative who handed my mother-in-law

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a letter to sign releasing the HMO of all financial responsibility for my father-in-law.

She would not sign it. We stayed in his office while several other letters were composed. She finally signed the fourth draft which stated: "You have agreed to pay $101.92 per day to the HMO and if Medicare does not cover plasmapheresis, you will pay for the cost."

The HMO requested this payment because they said, "Jackson Memorial is more expensive than the HMO hospital."

The following day, at 5 p.m., Louis A. Sposa was transported by ambulance to the Miami Hospital. On his arrival there, his doctor was stunned by his life-threatening condition. He had renal and lung failure.

Plasmapheresis would have to be postponed until he was stabilized. The doctor said to us: "No one needs to die of myasthenia gravis and I wish I had seen Mr. Sposa a week ago." He would have, had it not been for the HMO's refusal to move him.

At 8 a.m., May 22, 1984, Louis A. Sposa went into cardiorespiratory arrest and died in 2 hours.

The next problem occurred when the HMO did not pay his medical bills. I spent the next 10 months requesting payment from the HMO. I am told the final bill was paid March 16, 1985.

Following my father-in-law's death, we suggested that my mother-in-law return to the Medicare Program and obtain a supplemental insurance policy to pick up what Medicare would not pay. I telephoned the HMO to determine the nature of the disenrollment procedure. I was to write a letter to the HMO asking that my mother-in-law be disenrolled. They advised that she would be back on the Medicare rolls within 60 days.

On June 5, 1984, my mother-in-law signed a form withdrawing from the HMO. She received a letter shortly thereafter stating she would be back on Medicare on August 1, 1984. With this information, my mother-in-law went to her doctor in August and gave them her Medicare card. She began receiving Medicare rejections, stating she was still enrolled in an HMO.

I telephoned the HMO and was told that Medicare was slow in updating their records. I then telephoned the Jacksonville office of Blue Shield and was told that there was no record of her withdrawal from the HMO. I went back and forth between the HMO and Medicare until late November 1984. In the meantime, my mother-in-law continued to receive nothing but Medicare rejection notices.

Finally, I called Congressman Smith's office. His office said they would attempt to help me with this problem. They did. On December 1, 1984, 7 months after I sought to disenroll my mother-in-law in HMO, she was finally returned to the Medicare rolls.

As of today, she has not been reimbursed for medical expenses incurred during this period, which amount to over $1,000. The HMO's administrative malpractice has resulted in the premature death of my father-in-law, along with deep depression and loss of will to live for my mother-in-law.

In this short time, it is impossible to relate the emotional pain of my family over this experience. As you can see, handing the HMO's money to care for Medicare recipients does not necessarily result in good health care. I have personal knowledge of other mis-

handled cases under this system. Something must be done to correct it.

Ladies and gentlemen, based on this experience, it appears that the Government, by abrogating its responsibility, has created a new industry which is quick to take the monthly Medicare payments, but very reluctant to spend it for the purpose intended, providing senior citizens quality and timely medical care.

Thank you.

[The prepared statement of Ms. Sposa follows:]

PREPARED STATEMENT OF HELEN H. SPOSA, PLANTATION, FL

Mr. Chairman, Members of the Subcommittee. My name is Helen H. Sposa. I am here today representing my mother and father-in-law, Mr. and Mrs. Louis Sposa, of Plantation, Florida. Both were members of a Miami-based Health Maintenance Organization from 1982 to 1984. I am pleased to have the opportunity to relate to you their unfortunate experiences in attempting to secure health care—which I refer to as "administrative malpractice" and which I believe led to the premature death of my father-in-law in May of 1984.

In 1982, my in-laws—aged 68 and 71—enroled in a Miami-based Health Maintenance Organization [HMO], with offices in outlying areas including Broward County hear my in-laws' home. Both were in fairly good health at the time. Although my mother-in-law has a history of skin cancer and high blood pressure, my father-in-law had no medical problems to speak of. They joined the HMO with the belief that many of the services not reimbursed by the Medicare program, for example, eyeglasses and hearing aids, would be covered. I might mention that they did receive eyeglasses and a hearing aid shortly after joining the HMO—however, the glasses fell apart on the second day of wearing and the hearing aid was a step away from a horn which attached to one's shirt.

Early in 1983, my father-in-law began to experience double vision. HMO doctors said they could find nothing wrong with him and sent him home. For six months, he dealt with this problem before a Doctor finally diagnosed it as "Myasthenia gravis"—a disease of the nerve endings for which medication was prescribed. The medication, he was warned, could have side effects that might impair his breathing. Shortly after starting on the medication he did have an episode which required hospitalization. This was when we realized that the only hospital covered by the HMO was 25 miles away from my in-law's home. At this hospital, my father-in-law was treated by the same doctor who originally told him nothing was wrong. This episode disturbed my father-in-law so much that he said he would rather die at home than return to that hospital.

In May, 1984, my father-in-law began hyperventilating and was having a great deal of difficulty breathing. We took him to the emergency room at a local hospital where he was given a tracheotomy and put on a respirator. We were told that he required a procedure that only one hospital in the area could provide. Unfortunately, that was not the HMO hospital. It took my family 2 days of numerous calls between the HMO and Blue Cross/Blue Shield of Jacksonville to determine that the procedure that my father-in-law needed was a covered one. After finally overcoming this hurdle, the HMO then informed me that the hospital I was to send my father-in-law to didn't want to have anything to do with HMOs. It took an additional 6 days for me to convince the HMO that this was not the case. In was only then that they authorized the transfer of my father-in-law to the hospital that could treat his life-threatening condition. By the time that he did arrive, he was suffering from renal failure and lung failure—and the procedure had to be postponed until his condition stabilized. Doctors were stunned by the delay in his transfer which resulted in his deterioration. The doctor stated "there is no reason for anyone to die of myasthenia gravis—I wish I had seen Mr. Sposa a week ago." Had it not been for the HMO's failure to approve the transfer, my father-in-law would have been treated 6 days earlier! My father-in-law's condition never stabilized to the point he could benefit from the recommended procedure and he died of a heart attack four days after his arrival.

Following my father-in-law's death, we suggested that my mother-in-law return to the Medicare program and obtain a supplemental insurance policy to pick up what Medicare would not pay. I telephoned the HMO to determine the nature of the disenrollment procedure. I was to write a letter to the HMO asking that my mother-in-law be disenrolled. I was advised that she would be back on the Medicare rolls

within 60 days. On June 5, 1984 my mother-in-law signed a form withdrawing from the HMO. She received a letter shortly thereafter stating she would be back on Medicare on August 1, 1984. With this information, my mother-in-law went to her doctors in August and gave them her Medicare card. She began receiving Medicare rejections, stating she was still enrolled in an HMO. I telephoned the HMO and was told that Medicare was slow in updating their records. I then telephoned the Jacksonville office of Blue Shield, and was told that there was no record of her withdrawal from the HMO. I went back and forth between the HMO and Medicare until late November 1984. In the meantime, my mother-in-law continued to receive nothing but Medicare rejection notices.

Finally, I called Congressman Smith's office. His office said they would attempt to help me with this problem. They did. On December 1, 1984—7 months after I bought to disenroll my mother-in-law from the HMO—she was finally returned to the Medicare rolls.

I only hope that my testimony today will serve to spur this Subcommittee to take needed action to reform the administration of HMOs. Unfortunately, my in-law's experience is not an isolated one. There are many other sick older people who have experienced similar difficulties in securing health care, and do not have concerned relatives such as myself to assist them.

Thank you.

Mr. PEPPER. Thank you very much, Ms. Sposa, for your moving statement. Your ordeal is tragic.

Mr. Smith, would you care to inquire of the panel?

Mr. SMITH. Thank you, Mr. Chairman.

I am, as we all are, certainly concerned by the stories that we have heard because they are obviously indicative of what is going on. I think I would like to, for the record, state that I don't believe that the system itself is a bad one or that the system necessarily needs to be as it is right now. I think that a lot of the HMO's are honestly trying to do what is right and appropriate under the charge given them by the contract that they signed with the Government to provide these services, but that the Government itself does not allow them to do that by virtue of their bureaucratic ineptness. We need to really do something about that.

The testimony of Ms. Huddleston and Mr. Parks both indicate that they have difficulty in resolving problems, even if they are brought to their offices very early by the Medicare beneficiaries. So what might otherwise be a problem that would turn out to be resolvable with a minimum of problems in the long run may cost people a great deal of emotional trauma, as well as physical debilitation as a result of the inability of the system to deal with the problem effectively.

Ms. Huddleston, I am curious as to how many clients you see that have Medicare problems with HMO's and/or with the system. If you have a breakdown of what those problems relate to, the system itself and the way they were enrolled, the problem with this enrollment, the ability to receive health care, the quality of the health care and then ultimately whether or not, when they have gone to doctors, they have been charged for the services because the doctors get rejection notice assignment forms even though they are disenrolled, or they think they are disenrolled, how much of a resolution has been made by, if at all, the Medicare arbitration grievance procedure?

In other words, what is the breakdown of complaints? Where are the largest numbers and then, of course, plug in, if you would, what happens when you try to resolve some of these problems by calling HCFA or calling the HMO's.

Ms. HUDDLESTON. In the past 6 months, I think most of the problems that we have been seeing are with enrollments, people who don't know that they have enrolled in an HMO because they merely thought they were requesting additional information. That seems to be the problem that is coming in most. I would say about 50 percent currently come in for that kind of problem.

Thirty percent come in because they are having disenrollment problems.

Mr. SMITH. Let us stop there with the enrollment problems. You call, then—obviously, at that point, you call the HMO, rather than calling HCFA, because the HMO is responsible for the enrollment of these people. What is the response of most of the HMO's?

Ms. HUDDLESTON. During the past month, they have been responding finally. They return my phone calls within a week of my having made it, and they respond to my letters within 2 weeks of my having written it; as opposed to a year ago, I never got any response at all from anyone.

So I think they are trying harder. They are having much more pressure put on them now to do that.

Mr. SMITH. Have they ever indicated to you that they have a problem of their own—they have paid other firms, outside firms, headhunting firms, solicitation firms, to do this and they feel they are not responsible for some of the poor practices performed by these solicitation firms?

Ms. HUDDLESTON. I haven't been told that by an HMO employee, but I have heard that from other sources.

We see a lot of problems with disenrollment, problems like I discussed, when people tried to disenroll, and for some reason or another, it never gets on the Medicare computer and they still show him as an HMO member. But also along with that kind of disenrollment problem is the out-of-plan services that a lot of people have after they think they are disenrolled and are, therefore, left with large medical bills.

Mr. SMITH. That is the gray area. They are told they are going to be off the rolls; they go to their own doctor; the doctor takes the card, sends in the form and it is rejected.

Ms. HUDDLESTON. Right.

Mr. SMITH. Now, at that point, you have to call the HCFA people, not the HMO. Is it your understanding, because it is mine, that most of the time that disenrollment form has, in fact, been submitted by the HMO and now, frankly, most of the problem is because the Government has not had an adequate computer operation and those people are just not getting through into the disenrollment side of the Medicare list?

Ms. HUDDLESTON. Frankly, the HMO usually blames it on HCFA and HCFA usually blames it on the HMO. I haven't been able to get a straight answer as to who's responsible for the failure to process a disenrollment request from anyone.

So I would say the remainder of the problems that we see are people who come in complaining about the quality of care and the long time that it takes to get appointments when they think that they need to see a doctor.

Mr. SMITH. Have you found any out-and-out what I would consider to be fraud by people being told directly that they can go to any

doctor they want; they can continue to use their family physician when they enroll, when, in fact, most of the plans require that you give up freedom of choice in exchange for receiving all of the health benefits?

Ms. HUDDLESTON. I haven't been approached by anyone who has that particular problem.

Mr. SMITH. That is good to hear.

Ms. HUDDLESTON. Yes. We have been trying to rectify these problems through the appeals process, pursuant to the Federal regulations that Medicare beneficiaries have, and it appears that the HMO doesn't know what to do with these appeals when they get them or Social Security doesn't know what to do when an appeal is filed at Social Security in reference to an HMO problem.

Mr. SMITH. Thank you.

Ms. HUDDLESTON. Talking a year.

Mr. SMITH. Mr. Parks, I might ask you: You do something comparable in California to what Ms. Huddleston does in Florida. In response to my questions, how do you find the breakdown of complaints and how do you find dealing with the individual HMO's on the enrollment problem or with HCFA on the disenrollment problem?

Mr. PARKS. My comments would be very similar. What we have—first, I should say that we have a smaller number of people actually coming to our offices, the Medicare advocacy project, raising these complaints. And again, I would reiterate that one of the main reasons for this is that people don't know they can complain about these things. Many people don't know that they are in this predicament because they don't even understand what the HMO is all about.

Mr. SMITH. How many people participate in the demonstration project in your area? One of the problems is it is a much smaller project than the one in south Florida.

Mr. PARKS. It is both much smaller and much more recent in vintage. At the time the GAO study was done in south Florida, they accounted for about two-thirds of all the enrolled people in the demonstrations throughout the country. In addition, south Florida had been, as you know, inundated with sensationalized newspaper reports of the predicaments of some individuals. Your office was flooded with a number of people raising complaints.

That kind of negative publicity, which is very unfortunate, helps bring other people forth to raise their complaints. In my project, we have gone around making some presentations at senior centers, alerting them to what an HMO is and what some of the pros and cons are, I hear people constantly saying, oh, they didn't know those things and, in fact, they have a friend who has this problem; can something be done about it?

So we have a smaller number of—but they are similar. I would like to add, also, in terms of your question of fraudulent practices, I would seriously doubt whether anything that we would call fraud is actually taking place. At the same time, there are things which clearly would seem to be prohibitive by the regulations.

Let me give you two examples. No. 1, the regulations have always said that an HMO cannot offer money in return for people signing up. Presumably that is targeted at them not being able to

tell people: "We will give you $25 if you sign up." However, at least one HMO that I am aware of has sent letters to senior center directors and other people saying:

> We would like to have a presentation about our HMO at your center. In return for your allowing us to do this, we will give you $25 for every person who signs up that day.

It seems to me that that is very questionable under the regs.

What about advertisements that say, "Here is our plan. Pay no more premiums." Obviously, these ads are directed to people who may be paying Medicare supplemental premiums, but many people think that this means that they won't have to pay the Medicare part B premium any more, which, of course, is not the case.

There is this kind of aggressive and, to me, very misleading advertising that goes on all the time.

Mr. SMITH. Have you read the new regulations?

Mr. PARKS. Yes.

Mr. SMITH. What do you think about those regulations in light of what you just said? Will they correct those problems?

Mr. PARKS. The regulations give anyone the authority to address those problems. As I said, the regulations say you can't have misleading or false or fraudulent advertising. You can't make these payments. They talk about other deceptive practices. They also say that—they have always said that people should be fully informed before they enroll in HMO's.

It doesn't seem to me that an HMO that visits a senior center and signs people up the very day that they first see them is affectuating an informed enrollment on the part of those people, and yet, this goes on all the time.

Mr. SMITH. Thank you.

Thank you, Mr. Chairman.

Mr. PEPPER. Ms. Sposa, may I ask you two or three questions. You said it took about 8 months to get your mother disenrolled from her HMO.

Ms. SPOSA. Yes.

Mr. PEPPER. During this time, what communication, if any, did you have from HCFA?

Ms. SPOSA. None, none; we got no communication. The only communication we got was Medicare rejections. That was it.

Mr. PEPPER. Did HCFA ever give you an explanation as to what the cause of the delay was?

Ms. SPOSA. No, sir.

Mr. PEPPER. Did any of the correspondence your mother or father received from HCFA or the HMO spell out for them what they could do if they disagreed?

Ms. SPOSA. They do say—yes, there is a—the HMO says they have a group that would handle any discrepancies which—I attempted to call them at one point after my father-in-law had died because they continued to bill my mother-in-law for all these bills. I spoke with a lady. She filled out a form and she mailed me the form. That was it.

Mr. PEPPER. This hearing is of special interest to me. I have supported—as Ms. Davis, who is here, I guess; she is to testify later—will know. I have encouraged the Government to give these HMO's

a chance to participate in these demonstration projects and there are several of them that are in progress in south Florida.

I am just becoming aware of the multitude of problems that lie in association with the program. I had one of my Chinese friends the other day come to my office in Miami and he brought a doctor with him. They were talking about three of his Chinese friends, Chinese background; they live in Miami, who had tried to disenroll from an HMO and they hadn't been able to do it with any success. There had been the case of a serious illness where the former doctor of one of these covered men had said the man was losing blood pressure very rapidly and needed to get into a hospital emergency room right away. They said they had to wait 1½ hours before they could get permission from the HMO to get into the emergency room of the hospital.

I can see that it costs that HMO every time they allow anybody to receive a service, and therefore, they have to control, I suppose, the services rendered. So that anything you do evidently has to be approved by somebody before you can get it, before you can do it.

That means people couldn't also get an ambulance. They couldn't find anybody to approve having an ambulance to take him to the emergency room of the hospital, so his old doctor took him in his car and carried to the emergency room.

Now, I called up the State commissioner of insurance who regulates these activities in Florida. I said, you are going to have to establish close supervision over these HMO's. They affect the lives of too many people. They make mistakes like everybody else does and we have got to set up a system of Federal and State regulation and supervision that will assure that people will get the service that is vital to their lives oftentimes and services vital to their health.

So the HCFA and the Cabinet officer who is responsible for it, it seems to me, are going to have to examine this whole situation very thoroughly and very carefully and see to it that they have somebody in the community. I think HCFA and the State agency that regulates the HMO ought to have somebody available all the time so that if somebody is having trouble, they can call one of those Federal agencies and say, "Please look into this thing. I can't get in a hospital; I can't do this, that or the other." See to it that they get what they are entitled to get.

Now, I was one of those that urged the HMO's at home to include hearing aids. I know hearing aids—I know how important they are to people whose hearing is impaired, yet I know they cost $500 or $600 to get them installed. A lot of people who need hearing aids don't have the money to install them, so I encouraged these HMO's to tell the people you are going to give them eyeglasses and some dental care and some hearing aids.

But one of you testified, I think it was Ms. Sposa, that the hearing aid wasn't any good. That troubled me. If that is the kind of hearing aid they are going to be given, that wasn't what I was talking about. I mean for them to have the best hearing aid there is on the market because they will need it.

In the same way, they said the eyeglasses fell apart. That troubles me because I don't know why the eyeglasses should fall apart. Either they are inferior in quality or eyeglasses don't fall apart.

So this is a good idea. I don't want to condemn the idea of HMO. I think it is moving in the right direction. I am going to call a meeting on the 1st of May of this year, which I hope may lead toward the establishment of a medical system in this country under which every man, woman, and child, by paying whatever he or she can, will get the medical care he or she should have.

I think America owes that to its people and I think the genius of America can provide it. So we are going to have about five or six of the top insurance companies of the United States, who, I think, must have a very large part in such a program; the executive director of the American Medical Association; the president of the National Hospital Association; the head of the Kaiser group health agency in California and a lot of other knowledgeable people. We are going to sit down and say, "Now, ladies and gentlemen, we are just here to begin to think, almost preferable to plan, to see if we can't develop a better medical system in this country than we have got today and how the HMO's can play a very important part."

I have told their proprietors from the beginning the quality of your service is going to determine the ultimate success of your enterprise. If your quality doesn't hold up, these folks are going to be telling one another about it and they are going to be telling the public officials about it and there will be a discredit of your organization. I think they have done a wonderful job so far, but there are so many people involved and if every one of those services rendered has to be approved by somebody, you can see somebody has to be on the alert all the time to be available.

This business of waiting 6 to 7 months to be reestablished under Medicare care is ridiculous. Maybe we should take the transfer out of the hands of the HMO's and put it entirely in the Government. If you want to disenroll—you notify the Government and they will arrange it. They notify the HMO you are getting disenrolled at such-and-such a time.

I know there may be bills outstanding and there may be reasons why they have to have a reasonable length of time to do it, but we have got to speed up these procedures so people won't be wandering around and that thing about not being told at Jackson Memorial Hospital—they could go to Jackson Memorial Hospital—somebody ought to have been prosecuted for that.

Ms. SPOSA. I agree.

Mr. PEPPER. There is no sense in that. Why couldn't in one hour somebody say, "Yes, I know about that. You do need the surgery or you need the medical care that you can get at Jackson Memorial. We will have an ambulance over there in half an hour to pick you up."

When you are dealing with human lives and human health, you have to be prepared to render that kind of service. I think this is a very meaningful and very important hearing and we are looking forward, of course, to hearing later from the GAO and then, of course, from HCFA.

Mr. Regula, do you have questions?

Mr. REGULA. Thank you, Mr. Chairman.

Ms. Huddleston, just one question. Do you think the problem really flows from a communication gap between the enrollee and the institution, which may be caused by misleading representations

to the individuals involved and perhaps, if so, what would you suggest as a way of ensuring that all parties understood the relationship?

I think the chairman has outlined clearly the result of a communication problem because they don't—disenrollment, et cetera—so is that the problem, and if so, what is the remedy?

Ms. HUDDLESTON. I am not sure what the remedy is. I know that currently when someone requests enrollment or when HMO believes that someone has requested enrollment, they make a follow-up telephone call to the potential member and they have a checklist of questions that they ask and they just check them off and the interviewer signs their name. That is how they double-check to make sure that the person really wants to be enrolled. I don't think that is sufficient. I think they need to have a personal conference with more than one person and with someone who speaks the potential member's language and who can communicate.

I think that they need to provide forms in potential member's language. In south Florida, we have a lot of Spanish-speaking clients who don't always get enrollment forms that are written in Spanish. They do have Spanish forms; they just don't use them all the time. To negotiate in a language other than English, I think that they need to supply the forms in the language it was negotiated in.

Mr. REGULA. So you are really saying, if you improve the communication and make sure that the enrollee understood clearly what the circumstances were surrounding this decision to be part of an HMO, that this would certainly be helpful.

Ms. HUDDLESTON. It would take care of a lot of the problems. It is not going to help the computer foulups that keep happening or the failure of HCFA and the HMO to communicate adequately between each other.

Mr. REGULA. You think there should be more supervision of the HMO agreements by HCFA?

Ms. HUDDLESTON. Without a doubt.

Mr. REGULA. Thank you, Mr. Chairman.

Mr. PEPPER. Thank you very much, Mr. Regula.

Mr. Boehlert.

Mr. BOEHLERT. No questions.

Mr. PEPPER. Ms. Schneider.

Mrs. SCHNEIDER. Mr. Chairman, I have no questions, but I would like to have some extra time with panel that discusses the solutions. I would like to have some extra questions for them. I am, unfortunately, all too familiar with the problems myself, representing a district that has one of the highest concentrations of senior citizens, so I would like to pass at this time.

Thank you.

Mr. PEPPER. Thank you very much.

Thank you all very much. You have been an excellent panel and we appreciate your valuable contributions.

Our next witness is Mr. Mike Zimmerman, Associate Director, Human Resources Division, General Accounting Office, Washington, DC, accompanied by Mr. Robert Iffert.

Mr. Zimmerman, we would be pleased if you will take the table.

Thank you very much for coming, Mr. Zimmerman. We will be pleased to hear from you.

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROBERT IFFERT

Mr. ZIMMERMAN. Thank you, Mr. Chairman.

We are pleased to be here today to discuss the results of our ongoing review of Medicare's HMO demonstration projects in Florida and I have brought with me today, Mr. Iffert, and he is responsible for the work that we are doing on this project.

My statement will focus on the coordination problems that we identified between Medicare and the HMO's which resulted in duplicate or other erroneous payments to the HMO's, hospitals, physicians or beneficiaries. I will also discuss problems we identified with the enrollment and disenrollment procedures which can result in some beneficiaries being liable for substantial medical expenses.

We believe that HHS needs to correct the coordination problems now in view of the imminent nationwide expansion of Medicare's HMO Program and the potential adverse effects on beneficiaries and the provider community if other HMO's experience such problems. These matters are discussed in our March 8, 1965, interim report.

The demonstration projects and the HMO's that will participate in Medicare under the nationwide program differ from most previous HMO-type Medicare arrangements in two respects: First, the new program puts HMO's at risk because they are paid a fixed or capitated payment to provide all covered services; second, enrolled beneficiaries are required to obtain all their health care, except emergency or urgently needed services, from the HMO unless authorized by the HMO to obtain services elsewhere. This is known as the "lock-in" feature.

Neither the HMO nor Medicare is obligated to pay for unauthorized, out-of-plan services. The beneficiaries are personally liable.

Of the $2.6 million in claims for out-of-plan physician services that we found at the four Florida HMO's, the regular Medicare Program correctly denied $1.9 million and incorrectly allowed about $750,000, or about 29 percent. The amounts paid represent duplicate payments because the cost of the services were included in the payment rates to the HMO's. We believe that the 29 percent error rate is way too high.

In most cases about which we inquired, Florida Blue Shield, the carrier in Florida responsible for making payments to physicians, told us the incorrect payments occurred because of delays by HCFA in notifying the carrier that the beneficiary has enrolled in the HMO. According to the carrier, weeks and months passed before it was notified of enrollment dates. The carrier paid any out-of-plan claims submitted in the interim because it was unaware of the beneficiary's HMO enrollment.

In addition, the Medicare carrier is supposed to transfer denied claims to the HMO so that the HMO can review and consider paying them if they were authorized services or if the beneficiary

had adhered to HMO requirements. However, at the four HMO's, we could locate claims for only about 60 percent of the billed charges for the beneficiaries we examined in detail. To the extent the remaining claims were not submitted to the HMO, it could not act on them.

This could result in beneficiaries or providers not being reimbursed for medical services authorized by the HMO, but properly denied by the carrier. Our analysis of hospital bills indicated that HCFA's internal controls for coordination the HMO's hospital-related services with a regular Medicare Program were also highly vulnerable to error. In about one-fifth of the hospital admissions we reviewed, HCFA had not advised Blue Cross, the principal intermediary in Florida for paying hospital bills, that the beneficiaries were enrolled in HMO's.

When HCFA does not give the intermediaries beneficiary enrollment information, various hospital-related payment errors can occur because intermediaries use this information to determine who will pay for services provided, the HMO or Medicare.

One apparent cause of the enrollment information problem was the lag times between the effective date of enrollment and the recording of those dates in HCFA's information system. For a 13-month period ending January 1985, the enrollment information was recorded from 16 to 37 days after the effective enrollment dates. To the extent that HCFA received inquiries during these lag periods, it would have provided incorrect responses.

The correct enrollment information, along with other coordination problems between HCFA, the intermediaries, the HMO's and the hospitals, led to the following undesirable situations: Hospital bills were incorrectly paid, but the related bills for physician services were correctly denied, which could cause beneficiary confusion concerning the lock-in procedure; the cost of hospital services authorized by the HMO's were not correctly charged to them, resulting in program overpayments; the cost of hospital services not authorized by the HMO's were charged to them, which resulted in underpayments to the HMO's or Medicare payments for noncovered services; and finally, HMO's did not pay beneficiaries' Medicare cost-sharing amounts as provided under the HMO's benefit structure.

In addition to the coordination problems, we identified two other problems associated with the lock-in provision and the enrollment and disenrollment procedures. The first problem relates to who is responsible for the cost of services provided to beneficiaries who are hospitalized on the effective date of their enrollment. The second problem relates to beneficiaries who obtain out-of-plan services during the period when they have a signed a disenrollment form, but must continue to obtain services through the HMO until the effective date of disenrollment.

Medicare's enrollment regulations and procedures do not clearly spell out the status of the beneficiary who is hospitalized after signing an enrollment form for an HMO and is in the hospital on the effective date of HMO membership. We identified 7 out of our sample of 64 cases in which a beneficiary was in this situation. In all seven cases, most of the related doctor bills for services provided on and after the enrollment date were denied by Blue Shield be-

cause its records showed that the beneficiary was enrolled in an HMO.

Although the incidence of such cases was relatively small, the financial effect on beneficiaries and their families can be significant. For example, in one case, a beneficiary was in the hospital on the effective date of his enrollment and he paid $5,747 in doctor bills denied by the carrier for service provided during his HMO enrollment.

One solution to this problem would be to clearly spell out——

Mr. PEPPER. Just a minute.

Mr. ZIMMERMAN. Yes, sir.

Mr. PEPPER. What was that now? You said, during his HMO enrollment. What do you mean by that? Was it after he was enrolled?

Mr. ZIMMERMAN. Yes, sir. He went into the hospital after he signed up with the HMO and the situation developed that the beneficiary submitted the claims for the physicians' services, but the record showed that he was not actually in the HMO yet. So, as a result, the—excuse me, that he was in the HMO and, in fact, the carrier denied the claims in recognition of the fact that the person was in the HMO.

The HMO probably should have paid the claim.

Mr. PEPPER. Did he have approval from the HMO to go into the hospital?

Mr. ZIMMERMAN. No, because he was in the hospital before he became a member, but after he signed up for the HMO. He was in the hospital at the time he became effectively enrolled in the HMO.

Mr. PEPPER. He didn't apply to the HMO for approval of his remaining in the hospital?

Mr. ZIMMERMAN. I might ask Mr. Iffert to comment on that particular point.

Mr. IFFERT. No, this is one of those lag time problems, Senator, where—let's say he signed an enrollment form, say on the 25th, so he would then become eligible on the 1st of the following month. That is when he would become an HMO—but during this lag time, he got sick.

Mr. PEPPER. The rules of the HMO provide that——

Mr. IFFERT. The HMO never authorized that admission because he was never a member——

Mr. PEPPER [continuing]. You don't get benefits until the 1st of the following month.

Mr. IFFERT. Right. Right. In that lag time, he was hospitalized. Then, of course, Medicare paid his hospital bill.

Mr. PEPPER. Did Medicare pay the bill?

Mr. IFFERT. Medicare paid the hospital bill because at the time he was hospitalized, admitted, the records correctly showed that he was not a member of an HMO. But then on the effective date of his membership, his part B coverage, to put it bluntly, was effectively cut off. The HMO didn't authorize the admission. He was one of these people who, under the system, fell through the cracks with an awful lot of money involved.

Mr. PEPPER. Well, now, you are talking about after the 1st of the following month.

Mr. IFFERT. He was still in the hospital.

Mr. PEPPER. Yes.

Mr. IFFERT. And all the doctor bills that he incurred after that——

Mr. PEPPER. But under their rules, he had to have the approval of the HMO before they would pay the bill, is that it?

Mr. IFFERT. The HMO was not involved in his hospitalization at all because he was not a member of the HMO at the time he got sick. He had just signed a form and then the system started moving and the computer started going around and——

Mr. PEPPER. When did he become entitled to the benefits of the HMO? I thought you said the first of the following month.

Mr. IFFERT. He was, yes, but the HMO had not authorized that admission.

Mr. PEPPER. That is what I am getting at. The fellow that was in the hospital—was he in the hospital at the first of the following month?

Mr. IFFERT. He had been admitted before then and he was still there.

Mr. PEPPER. He was in the hospital on the first of the following month.

Mr. IFFERT. Yes, sir.

Mr. PEPPER. But he didn't take the pains to go back to HMO and say, "Now, I want you to approve my remaining in the hospital"?

Mr. IFFERT. No, because the HMO had not authorized that admission.

Mr. PEPPER. I know, but he was just staying on. Maybe Medicare could have paid up to the first of the month when the HMO should have become liable if it—but they have got the requirement that they have to approve everything, evidently, that you get. So this fellow was in the hospital. He signed up and the papers said that it would become effective the first of the following month. I guess he didn't think he had to get specific approval of the HMO to stay in the hospital. Is that it?

Mr. IFFERT. Actually that is what happened, yes, he did not get specific approval for him to stay there. Of course, he was under the care of some other doctors who had nothing to do with the HMO.

Mr. PEPPER. Yes, but Medicare would quit paying by that time, by the first of the following month.

Mr. IFFERT. They quit paying the doctor bills.

Mr. PEPPER. Well, there you are. You see, that is like out in the West. They tell us that in the early days of the country, they had a lot of railroad train collisions and the legislature in one of the Western States passed a statute. It said, "In order to avoid collisions hereafter, when two trains shall meet, neither shall proceed until the other has passed."

It is about like that.

Mr. ZIMMERMAN. Mr. Chairman, I have a possible solution to that problem that we are just talking about and that would be to clearly spell out in the regulations that regular Medicare would be responsible for services up to the effective enrollment date and the HMO would be responsible for the portion of the bills incurred afterward, even though it might not be practical to transfer the case's medical management to the HMO. An alternative would be for Medicare to be made responsible for all the costs until the pa-

tient is discharged and the monthly capitation payment could be proportionately reduced for the days involved.

What we are dealing here with are people who enroll in an HMO and then end up going into the hospital before the effective date of enrollment so they are kind of caught in a seam and we think there is a possible solution, or at least two options that can address that problem to assure that these people have appropriate coverage and are not stuck—like in this case here, with a $5,000 medical bill that no one is volunteering to pay for him.

What we just discussed involves a problem at the enrollment or front end and there was also a problem at the disenrollment stage.

The disenrollment forms include a statement that all services, except emergency or urgently needed services have to be provided or arranged by the HMO until the effective date of the disenrollment which, under the demonstration, should have been from 2 to 6 weeks later. Nevertheless, 14 of the 64 beneficiaries incurred substantial out-of-plan medical bills for which they were liable during the waiting period.

For example, one beneficiary entered a hospital 2 days after requesting disenrollment from an HMO and incurred $36,180 in claims during the disenrollment waiting period. Of this amount, $26,350 was owed by the beneficiary or was written off as uncollectible and $9,830 was incorrectly paid by Medicare. We believe that the regular Medicare coverage should be made available for beneficiaries who obtain necessary services during the waiting period between the date that they apply for disenrollment and the effective date.

In our opinion, beneficiaries who are dissatisfied with an HMO and believe they need medical treatment should not have to wait several weeks or months to obtain it. On the other hand, if it is eventually shown through complaints and grievances that an HMO was remiss in not providing needed services that a beneficiary obtained out-of-plan shortly after disenrollment, the HMO should be required to accept the responsibility for such services. This would discourage HMO's from withholding treatment as a means of encouraging enrollees with costly health problems to disenroll.

As indicated in my opening remarks, our testimony today covers our interim report. Our ongoing review of the four Florida HMO's will address such issues as their marketing and enrollment methods, actions being taken to assure quality of care is provided, their contracting arrangements with health care providers such as hospitals, medical specialists and the reasonableness of Medicare's HMO payment rates. We expect to issue our final report later this year and that concludes my statement.

We will be glad to answer any questions you or Congressman Smith or the members of the subcommittee may have.

[The prepared statement of Mr. Zimmerman follows:]

PREPARED STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and members of the Subcommittee, we are pleased to be here to discuss the results to date of our ongoing review of Medicare's health maintenance organization (HMO) demonstration projects in Florida. My statement will focus on the coordination problems that we identified between Medicare and the HMOs which result in duplicate or other erroneous payments to the HMOs, hospitals, phy-

sicians, or beneficiaries. We found that delayed recording of beneficiary enrollment dates and other coordination problems between Medicare and the HMOs led to:

Medicare paying non-HMO providers for services that HMOs had already been paid for;

Doctors not being paid or being paid more than once for services provided;

HMOs not paying beneficiaries' Medicare deductible and coinsurance charges for authorized services as called for under the Florida HMO agreements; and

Beneficiaries paying for services that the HMO should have paid for.

I will also discuss problems we identified with the enrollment and disenrollment procedures which can result in some beneficiaries being liable for substantial medical expenses.

We believe that the Department of Health and Human Services (HHS) needs to correct the systemic problems that lead to the situations outlined above. These problems include such things as carriers and intermediaries not knowing when beneficiaries are enrolled in an HMO and the breakdown in coordination among the carriers, intermediaries, HMOs, and the Health Care Financing Administration (HCFA). It is especially important to correct the problems now in view of the imminent nationwide expansion of the HMO program to serve Medicare beneficiaries and the potential adverse effects on beneficiaries and the provider community if other HMOs experience such problems. These matters are discussed in our interim report, "Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida" (GAO/HRD-85-48), which we issued on March 8, 1985.

The first part of my statement will discuss how the new HMO program operates, the number of HMO enrollees receiving services outside the HMOs, and the need for better coordination between Medicare and the HMOs in determining who should pay for such services. Then I will discuss problems with enrollment and disenrollment procedures which can result in some beneficiaries being liable for substantial medical expenses.

BACKGROUND

In February 1985, HHS initiated a program to expand the use of HMOs by Medicare beneficiaries. This new program was preceded by 26 demonstration projects throughout the country to test HMOs' effectiveness. The four Florida projects we looked at involved about half of all Medicare beneficiaries enrolled in the 26 projects.

The demonstration projects and the HMOs that will participate in Medicare under the nationwide program differ from most previous HMO-type Medicare arrangements in two respects. First, the new program puts HMOs at risk because they are paid a fixed per patient fee or capitation payment to provide all covered services. The capitation payment is to be based on the average Medicare costs for all beneficiaries in each HMO's service area. Second, enrolled beneficiaries are required to obtain all their health care, except emergency or urgently needed services, from the HMO unless authorized by the HMO to obtain services elsewhere. This is known as the "lock-in" feature, and any services obtained by beneficiaries without the HMOs authorization are referred to as "out-of-plan." Neither the HMO nor Medicare is obligated to pay for unauthorized, nonemergency services received from non-plan providers; the beneficiaries are personally liable.

NUMBER OF BENEFICIARIES RECEIVING OUT-OF-PLAN SERVICES

Of the 105,000 Medicare beneficiaries we compared with the payment files of the regular Medicare program, 6,737 (or 6.4 percent) had potentially [1] received some out-of-plan physicians' services while they were members of the four Florida HMOs. The total potential out-of-plan charges were about $2.6 million. In accordance with the lock-in provision, Medicare should deny (not pay) these claims. Based on all the denied claims, about half of the 6,737 beneficiaries had obtained out-of-plan services with charges of $100 or less, and about 9 percent had obtained such services with charges exceeding $1,000.[2]

Sixty-four people had obtained potential out-of-plan physician services for which they were charged from about $5,000 to about $17,000.[2] Our analysis of these beneficiaries' denied claims showed that the beneficiaries had paid about 14 percent of the

[1] We use the term "potentially" because during our review of individual cases, we found that the Medicare carrier had received claims for services that had been authorized by the HMOs and should have been submitted to the HMOs.

[2] Some claims for out-of-plan services were submitted to carriers and denied more than once; therefore, these amounts overstate the unduplicated incurred charges.

claims. The HMOs paid about 53 percent of the claims because (1) the services had been authorized by them and the doctors had sent the claim to Medicare by mistake or (2) when the HMOs learned of the circumstances, they decided to pay the claims. For the remaining claims, either the doctors had not been paid or we did not determine the status.

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR PHYSICIANS' SERVICES

Of the $2.6 million in claims for out-of-plan physicians' services related to the four Florida HMOs, the regular Medicare program correctly denied $1.9 million and incorrectly allowed almost $750,000, or about 29 percent. The amounts paid represent "duplicate" payments because the costs of the services were included in the payment rates to the HMOs. GAO believes that the 29 percent error rate is too high.

In most cases about which we inquired, Florida Blue Shield—the carrier in Florida responsible for making payments to physicians—told us the incorrect payments occurred because of delays of HCFA in notifying the carrier that the beneficiary had enrolled in an HMO. According to the carrier, weeks or months passed before it was notified of enrollment dates. We verified that one cause of these delays was the lag time at HCFA in recording HMO beneficiary enrollment dates. The carrier paid any out-of-plan claim submitted in the interim because it was unaware of the beneficiary's HMO enrollment.

Also, our analysis of the claims of the 64 beneficiaries noted that a coordination problem between the HMOs and regular Medicare in handling denied claims. The Medicare carrier is supposed to transfer such denied claims to the HMOs so that the HMOs can review and consider paying them if they were for authorized services or if the beneficiary had adhered to HMO requirements. However, at the four HMOs we could locate claims for only 60 percent of the billed charges for the 64 beneficiaries.

To the extent the remaining claims were not submitted to the HMO, it could not act on them. This could have resulted in beneficiaries or providers not being reimbursed for medical services authorized by the HMO but properly denied by the carrier. In some cases the HMO likely would have paid the claims because (1) the claims were related to hospital admissions that the HMOs had authorized, (2) the HMO had paid other related doctors' bills, or (3) the beneficiaries were not at fault. For example, one HMO paid $9,377 of $10,630 in claims originally denied by Florida Blue Shield for a beneficiary. The remaining $1,253 in claims were not sent to the HMO and, therefore, had not been paid at the time of our review.

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR HOSPITAL SERVICES

Our analysis of the hospital bills applicable to the 64 enrollees with denied physician claims of over $5,000 indicated that HCFA's internal controls for coordinating the HMOs' hospital-related services with the regular Medicare program were highly vulnerable to error. In about one-fifth of the hospital admissions we reviewed, HCFA had not advised Blue Cross—the principal intermediary in Florida for paying hospital bills—that the beneficiaries were enrolled in an HMO.

When HCFA does not give the intermediaries correct beneficiary enrollment information, various hospital-related payment errors occur because intermediaries use this information to determine who will pay for services provided—the HMO or Medicare. When a Medicare beneficiary is admitted to a hospital, the hospital notifies the intermediary, which in turn asks HCFA whether the beneficiary is eligible for service and is an HMO member. This information is passed on to the hospital. If the beneficiary is an HMO member and the hospital and HMO have a contractual agreement for providing services, the hospital bills the HMO directly. If the hospital has no agreement with the HMO, the intermediary will verify that the service is authorized (or an emergency) and will pay the hospital and tell HCFA to deduct the hospital payment from future capitation payments to the HMO. If the service is not authorized or is not an emergency or urgently needed service, the intermediary will deny the claim and notify the hospital, which in turn will bill the beneficiary.

One apparent cause of the incorrect enrollment information was the lag times between the effective dates of enrollment and the recording of those dates in HCFA's information system. For a 13-month period ended January 1985, the enrollment information was recorded from 16 to 37 days after the effective enrollment dates. To the extent that HCFA received inquiries during these lag periods, it would have provided incorrect responses.

The incorrect enrollment information, along with other coordination problems between HCFA, the intermediaries, the HMOs, and hospitals, led to the following undesirable situations.

Hospital bills were incorrectly paid, but the related bills for physicians' services were correctly denied, which could cause beneficiary confusion concerning the lock-in provision.

The costs of hospital services authorized by the HMO's were not correctly charged to them, resulting in program overpayments.

The costs of hospital services not authorized by the HMOs were charged to them, which resulted in underpayments to the HMO's or Medicare payments for non-covered services.

HMOs did not pay beneficiaries' Medicare cost-sharing amounts as provided under the HMOs' benefit structure.

In view of the imminent expansion of the HMO program nationwide and the negative effects that payment errors can have on the Medicare program, HMO's, service providers, and beneficiaries, HCFA needs to correct these problems. Corrective action should center on overcoming (1) the problems of intermediaries and carriers not knowing when beneficiaries are enrolled in HMOs because of the delays in recording enrollments and (2) the problems with the computerized exchange of data among carriers, intermediaries, HMOs, and HCFA.

OTHER ENROLLMENT AND DISENROLLMENT PROBLEMS

In addition to the coordination problems involving the HMO's and the administrative structure for paying providers under the regular Medicare program, we identified two other problems associated with the lock-in provision and the enrollment and disenrollment procedures. The first problem relates to whether and when the HMO's or the regular Medicare program is responsible for the cost of services provided to beneficiaries who are hospitalized in the effective date of their enrollment. The second problem relates to beneficiaries who obtain out-of-plan services during the period when they have signed a disenrollment form but must continue to obtain service through the HMO until the effective date of disenrollment.

Uncertain status of beneficiaries in the hospital on the effective date of enrollment

Medicare's enrollment regulations and procedures do not clearly spell out the status of a beneficiary who is hospitalized after signing an enrollment form for an HMO and is in the hospital on the effective date of HMO membership. Under the demonstration projects, this period could range from 2 to 6 weeks. We identified at least seven cases in which a beneficiary was in this situation. In at least five of these cases, Blue Cross had paid the hospital bill because the administration and HCFA's response to the inquiry about eligibility status were based on a date before the effective enrollment date. However, in all seven cases most of the related doctor bills for services provided on and after the enrollment date were denied by Blue Shield because its records showed that the beneficiary was enrolled in an HMO.

Further, because the HMOs did not authorize the hospital admission, their responsibility for these doctor bills was not clear. In four cases, the HMO had reviewed those claims it received and had paid all or part of them, but in two cases the HMO had not received any denied claims from Blue Shield and consequently had paid nothing.

Although the incidence of such cases was relatively small, the financial effect on beneficiaries and their families can be significant. For example, in one case a beneficiary was in the hospital on the effective date of his enrollment, and he or his wife had paid $5,747 in doctors bills denied by the carrier for services provided during the effective date of his HMO enrollment.

One solution to this problem would be to clearly spell out in the regulations that regular Medicare would be responsible for the portion of the medically necessary hospital and doctor bills up to the effective enrollment date, and the HMOs would be responsible for the portion of the bills incurred afterward even though it might not be practical to transfer the cases' medical management to the HMO. An alternative solution would be for Medicare to be made responsible for all costs until the patient is discharged, and the HMO's monthly capitation payment could be proportionately reduced for the days involved.

Services obtained during the disenrollment waiting period

Of the 64 individuals with total denied physician claims over $5,000, at least 14 began to obtain out-of-plan services within a week of the date they signed the HMO disenrollment forms. The forms included a statement that all services, except "emergency" or "urgently needed" services, had to be provided or arranged by the HMO until the effective date of the disenrollment, which under the demonstrations should have been from 2 to 6 weeks later. Nevertheless, these beneficiaries incurred substantial out-of-plan medical bills for which they were liable during the waiting

period. For example, one beneficiary entered a hospital 2 days after requesting disenrollment from the HMO and incurred $36,180 in claims during the disenrollment waiting period. Of this amount, $26,350 was owed by the beneficiary or was written off as uncollectable, and $9,830 was incorrectly paid by Medicare.

Under the Social Security Act, a member may terminate enrollment with an HMO no earlier than the first day of the second month following the month in which the HMO receives the request for the termination. We believe that regular Medicare coverage should be made available for beneficiaries who obtained necessary services during the waiting period between the date that they apply for disenrollment and the effective date.

In our opinion, beneficiaries who are dissatisfied with an HMO service and believe they need medical treatment should not have to wait several weeks or months to obtain it. On the other hand, if it is eventually shown through complaints and grievances that an HMO was remiss in not providing needed services that a beneficiary obtained out-of-plan shortly after disenrollment, the HMO should be required to accept the responsibility for such services. This would discourage HMOs from withholding treatment as a means of encouraging enrollees with costly health problems to disenroll.

As indicated in my opening remarks, our testimony today covers our interim report. Our review of the four southern Florida HMO projects will address such issues as (1) the HMO's marketing and enrollment methods; (2) actions being taken to assure quality care is provided; (3) HMO's contracting arrangements with health care providers, such as hospitals and medical specialists; and (4) the reasonableness of Medicare HMO payment rates. We expect to issue our final report later this year.

This concludes my statement. We will be glad to answer any questions you might have.

Mr. PEPPER. Would you like to add anything, Mr. Iffert?

Mr. IFFERT. No, sir, but I would be pleased to answer any questions.

Mr. PEPPER. Mr. Zimmerman, Ms. Davis will be here later and I hope we can present to her your proposal to clear up this hiatus as to who is responsible during the period of disenrollment for the medical care that may be obtained by the covered patient.

What do you find insofar as the overall effectiveness of the system? Is it doing a good job or does it need to be checked up? Is it not doing a good job? How would you evaluate what you have observed?

Mr. ZIMMERMAN. I think based on our work in Florida, it appears to us that the management and administration and the processing that the system must go through needs to be sharpened up, particularly if we are going to have a nationwide program of 10 or 15 times the size. There are a lot of systems involved here, a lot of interfaces. Things of that nature need to be smoothened out so that we don't have situations where people lose their benefit coverage or find that they are enrolled in a program they never enrolled in.

It is a very complex arrangement and it takes a concerted effort to resolve the problems.

Mr. PEPPER. We have been concerned about whether the HMO's would discourage, if not prevent, the enrollment of people who are high-risk patients, maybe those who are already ill or those who are in the advanced age stages. Do you find any evidence of discrimination in admission to enrollment on the part of the HMO's?

Mr. ZIMMERMAN. To my knowledge, we have not found anything of that nature. Maybe Mr. Iffert can add to it.

Mr. IFFERT. No; I think that is correct.

Mr. PEPPER. Well, I am pleased to hear that.

What would you recommend that HCFA adopt as rules and regulations to correct against many of the errors that you have discovered?

Mr. ZIMMERMAN. I think what they need to do is what I would consider a reliability assessment, an indepth evaluation of the systems they have out there. Are they working? If they are not working, why aren't they working and what is it going to take to make them work.

I think if this program is to be effective, these data bases have to interact correctly. In the computer, we are dealing with numbers; in reality, we are dealing with people. While the computer can play with the numbers all day long, it is pretty difficult in a case of some of the patients that we are dealing with here to put them in a position where it is uncertain as to who is paying for the health care or when that payment will be received.

So I think a focus by the administration, HCFA, the Department on the systems problems first so that regardless of whether you agree with HMO's or not, at least we put them in a position that they can work correctly and not be affected by deficiencies in computers and data bases and things of that nature which seem to be creating problems with the demonstration projects now.

Mr. PEPPER. Do you think there should be closer State and/or Federal inspection and supervision of the HMO's?

Mr. ZIMMERMAN. That is a very general question, Mr. Chairman. I think it is clear to me that the Health Care Financing Administration is going to have to spend a lot of time—at least in the infancy of this new program—to make sure it gets off the ground correctly and that the kinks and the problems with it are worked out.

As to whether, over the long haul, there is a need for that, I am not sure. Maybe Mr. Iffert might want to add.

Mr. IFFERT. They have to be fair to HCFA and to be fair to the office of HMO's in Rockville, they have exercised a considerable amount of monitoring. But, how much is enough? They certainly have not just let the HMO's do anything they want. They do approve their marketing materials for example.

Mr. PEPPER. We will talk about that in just a minute.

Did you find any instances where they were pushing people out of the hospitals too soon for their health's good?

Mr. ZIMMERMAN. Not to my knowledge. Again, I will refer the question to Mr. Iffert. Maybe he has some information I don't have available to me.

Mr. IFFERT. No, I don't think so, but going back through some of these cases, if we do identify any instances we will provide something for the record.

Mr. SMITH. Would the gentleman yield on that?

Mr. PEPPER. Yes.

Mr. SMITH. I thank the gentleman for yielding. I think that we are going to be having this kind of inquiry raised more and more as the DRG impact is measured on what is going on in terms of hospitalization of patients, including hospitalization of Medicare patients that are enrolled in HMO's. You did document, however, some severe problems relating between the HMO's and the hospitals in regard to payments under DRG; what the hospitals will accept from the HMO's and the like, did you not?

Mr. IFFERT. Well, there were situations where the so-called DRG payment, because of the seriousness of the individual's illness, may be approximately a fourth of the hospital's charges for that admission, but that doesn't necessarily mean that the DRG's are wrong. It is just that we were dealing with some very sick people.

Mr. SMITH. I understand, but my problem is—I mean, you detailed the problem thereafter, that the HMO's only wanted to pay the hospitals the DRG—you know, the hospital should accept the DRG and this is an entirely different concept because the HMO is supposed to be providing all the Medicare coverage, including payment in full of hospital bills.

Is there a rule that says that the hospital can only collect—if it is a HMO patient, the hospital can only collect the DRG, or can they bill the HMO in full for that?

Mr. IFFERT. In Florida, they have what they call the option B method for paying hospitals, which allows the hospital that does not have an agreement with the HMO to be paid by the intermediary, the fiscal intermediary. Of course, then the fiscal intermediary pays it at the regular Medicare rate.

Now, that arose because there was some conflict as the HMO movement started down there between the hospitals and the HMO's and a number of hospitals, in effect, were boycotting the HMO patients. So to resolve that problem, HCFA developed the so-called option B, which allowed the hospitals who wanted to to bill the intermediary and, of course, get paid a lot more promptly. A number of hospitals have exercised that option and those hospitals are paid on the basis of the DRG's or under the prospective payment system.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. PEPPER. Let me finish this. You see, before the HMO came into the picture, the doctor—and before the DRG Program—the doctor determined who went into the hospital, assuming the hospital admitted the patient.

Mr. IFFERT. Yes.

Mr. PEPPER. It was supposed to be a medical decision. The doctor, while he had a patient in the hospital and he could go see every day and charge $75 or whatever it is they charge when they go see a patient in the hospital, but it wasn't so intimately related to his profit-and-loss situation as it is when the HMO's profit, as an organization, is determined by the care that it gives.

So everything that costs money somebody has to approve, I see. Otherwise, I reckon the expenses would just run out of hand. Well, if every time somebody wants to go to an emergency room or needs to get in the hospital and needs some medical care, they have got to have somebody's approval, why it is obvious that they must have a lot of people available—we down home—we have thousands and thousands of elderly people who enrolled in HMO's. Maybe 25 of them will need to go to the hospital at the same time.

I want to be sure that the HMO has got enough people in critical positions so immediately an ill person can get them on the telephone or invite them to come to see them and get an approval or a rejection. And then if they reject it, I want some governmental authority in the area to be able to examine it and, if necessary, over-

rule it on the ground the individual does need that care, in spite of the fact they don't want to incur any more expense.

So if we are going to protect the people, there has got to be efficient administration of these programs. Now, these people may have been correct in telling me that they had to wait 1½ hours to get somebody's approval to go into an emergency room. What if you had an automobile accident and you were bleeding very profusely? Are you going to find somebody that can give you permission to go into a hospital? Or maybe they are all off or they are busy or having lunch and the fellow lies there and bleeds.

That is the kind of thing, it seems to me, that is going to require expert, as you said, expert and very efficient administration on the part of the HMO's. It seems to me close supervision is needed on the part of the State and Federal authorities to be sure the system is operating. It is big and it is complicated. It will be difficult to have it operate with the efficiency, maybe, that we would like to see, but if we don't have somebody checking right behind these things, why, I am afraid a lot of people are not going to get what they should by way of treatment.

Now, you have reported that HCFA has, in your opinion, not done a lot of things it should have done. The administration of the Government has not been as efficient. Their computers are not adequate to handle them properly, and the like. It is not done with timeliness and alacrity as it should.

The Government of the United States—as broke as we are, we can still buy some more computers, I would think, and so we are going to ask Mrs. Davis about what they can do to make their supervision more effective.

We are for the HMO concept, but we are more for the people of this country getting the medical care that they should have.

Mr. Smith.

Mr. REGULA. Excuse me, Mr. Chairman.

Mr. PEPPER. Yes.

Mr. REGULA. I would like unanimous consent to submit questions for the record.

Mr. PEPPER. Sure, without objection, it will be permitted.

Mr. REGULA. Thank you.

Mr. PEPPER. Thank you very much, Mr. Regula.

Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

I want to state again how much I appreciate your cooperation in reviewing the report which I asked the GAO to do and then scheduling these hearings. I think it is extremely important and you just detailed some of the problems that arose and the complaints we had in my office and the documentation provided by the GAO report.

I would like to say that the GAO really needs to be commended for the work that they did on this. This was not an easy one for them. We had a number of meetings in my office with Mr. Iffert and a number of the other people that are here today from the GAO and Mr. Zimmerman and they had to really go through real hell to pull this information out. The information processing was so backward and in such ancient encrypted coding that it was really on paper—and we are trying to get away from paper——

Mr. PEPPER. May I interrupt you to say that I have been here 36 years in the Congress and that is the record the GAO has had as long as I have been here, so your excellence is very much appreciative.

Mr. ZIMMERMAN. Thank you very much.

Mr. SMITH. They did a good job. They also showed a dedication to it, which was quite interesting. They felt it was a very important issue to take hold of.

Mr. Zimmerman, you documented in the report large numbers of problems about nonpayments, duplicate payments, people falling through the cracks and the like and some of the things that need to be done to alter the situation. You also documented the fact that HCFA had a memo prepared for them themselves about expansion of the program being absolutely incapable of being supervised systemically, administratively, until such time as they could change a lot of the systems they had in place.

Have you, in the work that you did, noticed at all that the HCFA Administration is beginning to move forward with the changes necessary to implement system changes or anything else which would allow them to monitor what may be the crush of another 2 million people signing up into this program?

Mr. ZIMMERMAN. The impression we have now, and goes back even prior to the issuance of the report, that the Health Care Financing Administration certainly begins to recognize it has a very significant role and a big problem to deal with. It is my understanding, in fact, that the April 1985 postings, which were supposed to be theoretically in place on April 1, in fact, did take place April 1. This is the first time that they have ever been able to post—at least in the 14 or 15 months we have been affiliated with this issue—the additions and deletions from the HMO's on time, exactly when they were supposed to be done. So apparently they have arranged some of the priorities involving their work and Social Security and I have also been informed that they have made some system modifications so, at least in that aspect, they seem to be going forward and in the right direction.

Mr. SMITH. Now, you are also aware that the proposal of this administration for budgetary priorities leaves HCFA and HHS in a rather disadvantaged position; isn't that correct?

Mr. ZIMMERMAN. That is correct.

Mr. SMITH. In fact, there is a strong proposal—I think more than a proposal, but a movement in the budget process to cut out of HHS 17,000 positions. Right?

Mr. ZIMMERMAN. That is my understanding of it.

Mr. SMITH. Will they be capable—HHS and HCFA—of running this program with an additional 2 to 3 million enrollees, if, in fact, they are successful in cutting that many positions—and by the way, as a corollary, there are no new positions being offered at HCFA. Will they be capable of running this program, which is now 190,000 to 200,000 when it reaches 2 to 3 million with a big cutback at HHS and no new positions at HCFA?

Mr. ZIMMERMAN. It is my understanding—I am not trying to beg the question that the reduction in staff at—I think it applies principally to SSA—it will be something done down the road in the somewhat distant future. As to what effect that would have on the

program, it is hard for me to say since, at this point in time, it is my understanding that HCFA does not rely to any great degree with Social Security's involvement in their field offices in administering the program.

That is not to say that if we expanded the program and brought in a million or two people, that that need for the field offices to be involved wouldn't materialize. I guess in summing it up, I think it could pose a potential drain on the Social Security System and HCFA if the system starts off with a lot of problems requiring the involvement of both Social Security and HCFA staff. I think they ought to look into that and make sure that their staffing levels are sufficient to meet the challenge.

Mr. SMITH. Given those problems, do you think it is a wise idea to go nationally with this program? Mrs. Davis, in response to my questions, indicated that they are mandated, under TEFRA, to do that when they have finished their review of the county-by-county average yearly costs—what do they call that, the——

Mr. IFFERT. The AAPCC.

Mr. SMITH. The AAPCC, right. They said they had just completed it, therefore, they were moving forward. Given the fact that they have the memo that told them they couldn't move forward until they had made major changes—which they haven't made—do you think it is wise for us to proceed to open this up to 2 or 3 million additional beneficiaries in the next year or two alone? Remember, 27 million beneficiaries as of now exist in the United States. We are talking about two or three, maybe, in the next year or so, but it could be 10 million in the next 4 or 5 years.

Is it wise to just rush into it? Don't you think there might be some benefit in sitting back and looking at how we can put on-line the systemic changes necessary to make sure the system works well before we go ahead and rush to the final opening nationwide of this program?

Mr. ZIMMERMAN. It is my understanding, Mr. Smith, that the administration does plan to take a good look at the processes it has in place and the needed changes to make them more responsive. I guess I would have to agree that if they are unable in the near future to come up with a system that is adequate to meet the challenges of the program, then they should give some thought to slowing down a rapid acceleration in the program.

Nevertheless, I am optimistic that the Social Security Administration and HCFA, with the resources that are available to the both of them, they will be able to design a system—maybe not right now, but at least in the near future, that can meet the needs of the HMO and the expanded HMO program.

Mr. PEPPER. Would the gentleman yield?

Mr. SMITH. I would be happy to yield.

Mr. PEPPER. I want to disassociate myself distinctly with any idea of curtailing the growth of the HMO. I think the HMO is in the direction of the future. It offers a better health system eventually than we have got at the present time. While I do insist that we have the supervision that we have been talking about here this morning and that we tighten our direction over it and the examination of its procedures and the like. I don't want to in any sense of the word discourage. I have encouraged the administration to go

ahead with the spreading of these demonstration projects over the country because the idea of the prepaid medical care program is in the right direction. It is just like over 50 years, I paid a premium on my home. I never recovered my $700 from the insurance company, but I always had assurance that if my home burned down, they would rebuild it or give me the value of it.

So the HMO is in the right direction, but it is a new thing in the health field and it has got to be supervised carefully. Those who run it have got to be supervised carefully. Those who run it have got to be very much aware of the heavy responsibility that they bear, but I don't want to discourage the growth of it. I think it is in the right direction.

Mr. ZIMMERMAN. I would have to agree with you, Mr. Chairman. I recall the problem Social Security had in trying to get the SSI Program off the ground. It was very difficult. In the first 6 months, there were a lot of problems, but ultimately it succeeded.

I think this is a program that is almost of comparable nature and it is going to require a special commitment and dedication on the part of the administration to carry it out. If that is not evidenced, then it is going to continue to have problems.

Mr. PEPPER. Thank you.

Mr. SMITH. Thank you, Mr. Chairman.

I agree to the extent that this is a valuable program, a very viable alternative to the normal fee for service. My question is based, however, on the response that I hope you are going to give me to this question: What statistics did you find that were collected overall by HCFA from these demonstration projects that in south Florida have been on line for almost 3 years? Besides the number of people that enrolled, would you kindly tell me what you were able to cull from HCFA that was so helpful in making this report up as opposed to what statistics you had to compile yourself that maybe they should have been compiling as the reason why you would have the demonstration project in the first place?

Mr. ZIMMERMAN. It is my understanding that the demonstration projects are supposed to be evaluated and I am not quite sure I know exactly when the evaluation report is due.

Mr. SMITH. Well, let me stop you there. Do you think it should be due before you expand the program nationwide or do you wait and worry about the statistics coming in after you have taken 112,000 from a demonstration project in Florida and expand it to 2 or 3 million nationwide and then you get the problems after you put on line a major system? Is that—from the GAO's point of view, as an accounting office, would you find that to be rather poor practice?

Mr. ZIMMERMAN. I think the decision to expand the HMO Program was made absent the evaluation of the demonstration projects. I think that is clear. Our feeling on the matter is that that was a policy decision that was made. It was a response to legislation authorizing that action to be taken and I cannot say that as a result of our evaluation of the HMO's, that we would go on record as being opposed to the establishment on a national basis.

Mr. SMITH. I didn't ask you to take that position. I am not opposed to it, either. I want to make the distinction as to the timetable, whether or not we should be going at it immediately, and I am curious as to whether Mr. Iffert can answer the question with ref-

erence to how much statistical data he was able to get after the 3 years of demonstration projects in order to enable him to make up this report.

Mr. ZIMMERMAN. I will ask him to answer that question.

Mr. IFFERT. Obviously from the report that we issued and almost everything that we did, except for gross data on enrollments, payments and that sort of information, involved original work; by us, but that was the way the assignment was designed. The way it was designed was to develop original data; to find out just how many people in the universe of 100 and some thousand that enrolled down there, did go out of plan and, quite frankly, the data indicates that about 95 percent of the people did understand the lock-in provision and of the people that did go out of plan, there was a very small group—maybe 500 or 600—who really ran up some very, very catastrophic medical bills for which they were responsible.

So that all involved original work by us, but, here again, that was the way the assignment was designed because that is what you asked us to do.

Mr. SMITH. One final question: The report indicates, according to that small group that went out of plan and then ran up large bills that were not reimbursed, that it was about $700,000, either in nonreimbursable to duplicative payments which cost ultimately somebody money.

Now, unless the changes are made, am I correct that you could assume that maybe that would be about an average in the whole scheme of things as the program would grow nationwide? Wouldn't that result in a large amount of money being wasted to the U.S. Government itself in duplicated payments——

Mr. IFFERT. Sure.

Mr. SMITH [continuing]. Unless we put on line a program to change the way we administer——

Mr. IFFERT. Sure. I mean, the posting problem was not limited to Florida. It applied to every HMO in the country.

Mr. SMITH. Finally, I asked you, in addition to the first overview, which was really systemic problems, to do a number of other overviews in terms of the quality of health care and all the other things described by Mr. Zimmerman. When do you think you would have that report finalized?

Mr. IFFERT. We are working toward a September date and, if I don't have to go back in the hospital again, we will try to make it.

Mr. SMITH. I appreciate it very much. I think you did a terrific job on the interim report—documented and uncovered large problems that need to be addressed specifically. I hope that you are getting the cooperation from HHS and HCFA that you are seeking.

Mr. IFFERT. Yes, we are trying to work together. We have the same objective. We want this thing fixed, too.

Mr. SMITH. Good.

I just have one final short question: Would you indicate for me what you feel is the current technological status of the Social Security computers which are the actual instruments used for the enrollment and disenrollment process which seems to be the single largest problem? How do you feel about the technological state of their computer system?

Mr. ZIMMERMAN. Mr. Smith, I am not in a position to assess their technological state. I know they have a system development project that has been underway for a number of years. It is a long-range project. A number of administrations past have recognized the shortcomings in Social Security computer systems. They are working toward solving them, but many people recognize it will be a long time before the Social Security Administration and everybody else is satisfied with the systems that they finally end up with. It is a very big project. GAO has spent a lot of time working on it and working with the administration and I think ultimately it will be a fine computer system.

Mr. SMITH. Are they getting a computer system in line—I am sorry, the software in line so that all the faces of this Medicare/HMO project nationally can talk to each other?

Mr. ZIMMERMAN. It is my—I think that might be a good question to ask Carolyne Davis. She might be more familiar with what their current activity in that area is.

Mr. SMITH. Thank you.

Thank you very much, Mr. Chairman.

Mr. PEPPER. Thank you, Mr. Smith.

We are going to have to move along a little bit.

Mr. Borski, any questions?

Mr. BORSKI. No, Mr. Chairman.

Mr. PEPPER. Mr. Kolbe?

Mr. KOLBE. No, I don't, Mr. Chairman.

Mr. PEPPER. Mr. Boehlert.

Mr. BOEHLERT. Thank you, Mr. Chairman. I share your enthusiasm for the concept and I also share the reservations by my colleague from Florida about proceeding pell-mell before we have the results of the demonstration projects so that we can correct the glitches.

I would only make one observation and that is, in the desire to pursue the latest and most modern technology—I agree with the chairman that, as broke as we are, we can afford that. I certainly hope that SSA and HCFA do not follow the example set by the Internal Revenue Service.

Mr. PEPPER. Thank you very much.

Mrs. Schneider.

Mrs. SCHNEIDER. I have several questions. One of the purposes of this study was to determine the need for better coordination between Medicare and the HMO's in determining who should pay for those services. You go on in your testimony and say that you will discuss the problems with enrollment and disenrollment procedures.

Could you tell me specifically where the responsibility lies in making that clarification? It does not require a legislative solution. It is my understanding that it would require either, an administrative solution and/or perhaps, just better training on the part of those local administrators who are implementing this.

Mr. ZIMMERMAN. The additional enrollment, and I will have Mr. Iffert chime in, especially if I am incorrect—I believe the disenrollment may require a legislative change. The enrollment procedure may or may not require a legislative change.

Mrs. SCHNEIDER. For disenrollment——

Mr. ZIMMERMAN. I think it is the disenrollment that requires the legislative change. Do I have that backward, Bob?

Mr. IFFERT. No, it is—well, the area of uncertainty involves the front-end enrollment. Prevously Senator Pepper and I had a discussion about the individual who fell in the cracks between the day that he signed his enrollment form and got sick. I think there was another example we mentioned in the report where the poor fellow was in a coma on the date he became enrolled.

Mrs. SCHNEIDER. So we are looking for——

Mr. IFFERT. That, I think, could be done by regulation, just to make it clear.

Mr. ZIMMERMAN. That is the enrollment side.

Mrs. SCHNEIDER. Providing us with two recommendations for solutions.

Mr. ZIMMERMAN. Those are two options, actually, yes.

Mr. IFFERT. We don't really care which one, as long as the beneficiary is protected. There is not that much money one way or the other.

Mrs. SCHNEIDER. I can assume that since this is an interim report, you will be coming up with additional recommendations how to solve this problem?

Mr. IFFERT. That is exactly correct, yes, ma'am.

Mrs. SCHNEIDER. Because you go on to say that even though it might not be the most practical way to, for example, to have the HMO's be responsible for the portion of bills incurred afterward, evidently there is a information transfer difficulty which seems to me could create even more of a bureaucratic nightmare——

Mr. IFFERT. There is a possibility.

Mrs. SCHNEIDER [continuing]. Your solution here that you are recommending.

Mr. IFFERT. On the what, the disenrollment or the enrollment?

Mrs. SCHNEIDER. On page 10 where you are spelling out solutions. Medicare would be responsible from the effective enrollment date and then the HMO's would be responsible for the portion of the bills incurred afterwards. Then you go on to say even though it might not be practical to transfer the case's medical management to the HMO.

Mr. IFFERT. That is a medical question. The person is not going to switch doctors——

Mr. ZIMMERMAN. While he is in a coma. In other words, the situation would be that if a person enrolls in an HMO and, on the effective date, he or she is in a hospital, then the HMO is just going to have to, under this option, pick up the cost without actually taking over the medical management of the case. That is the medical side of it.

It may make them a little unhappy, but I don't understand how one could insert a new medical team in the middle of a hospital stay successfully without creating problems.

Mrs. SCHNEIDER. Would it be necessary, under current regulations, to substitute a new medical team?

Mr. ZIMMERMAN. I think, under current regulations—the way I understand it, the HMO has to have the—has the authority to approve the services and I might add that some of the HMO's, when confronted with the situation, have waived that or just on its face

approved payment, rather than getting involved in a situation where someone falls through the cracks.

Our report points out that while some did fall, some did not and the HMO did, in fact, pick up the bill and pay it. I think it is the uncertainty that exists that needs to be cleared up. It has to be—beneficiaries have to be sure that somebody, whether it be the HMO or Medicare, is going to pay that bill and they are not going to get stuck with it when they incur reasonable and necessary health care costs.

Mrs. SCHNEIDER. I would like to just ask a generic question about informing the public. As you have been doing this study, aside from the clarifications that would be required from the Federal Government, what role do you see other bodies playing, whether they be the hospitals, local governments, citizens groups, whatever?

Mr. ZIMMERMAN. I think the educational responsibilities rest principally with HCFA and the HMO's. They are the principal agents involved in the new program. The HMO's are capable in communicating with the community as to what the programs are about and how they work.

I might add that local offices of the U.S. Government haven't found themselves very much involved as information sources because it seems like people weren't doing the full-scale job that one would need.

I think the Health Care Financing Administration can communicate directly with every Medicare beneficiary. Of course, you can rely on the help of the Social Security Administration and, of course, you have the carriers and intermediaries that are directly and indirectly involved in the process. So you have some rather very large competent groups that are in a position to provide needed information.

There should not be a lack of meaningful information going out there. There are sources of that information.

Mrs. SCHNEIDER. Thank you.

Mr. PEPPER. Thank you, Mrs. Schneider.

Mr. Iffert, I am informed that you are contemplating leaving the GAO, and if so, we want to commend you upon the excellent job you have done for our country, for our Government, and we want to wish you the very best success in whatever new endeavor you may undertake.

Mr. IFFERT. I appreciate that very much, Senator, and I hope to be—I am looking forward to being one of your constituents.

Mr. PEPPER. Good.

Mr. SMITH. Are you going to join an HMO?

Mr. IFFERT. No, Mr. Smith, I am not.

Mr. PEPPER. Thank you all, gentlemen, very much. Our next panel will consist of Carolyne Davis and Frank Seubold. Ms. Davis is Administrator of the Health Care Financing Administration, Department of Health and Human Services. Mr. Seubold is Director, Office of Health Maintenance Organizations, Health Resources and Services Administration, Department of Health Services.

Ms. Davis, you come right around.

Ms. Davis, I can attest from many contacts I have had with you from time to time about this general subject the good job you have done for our Government and our country and we want to express

our appreciation to you for the excellence of what you have contributed toward better health care for the people of this country.

We are delighted to have you here this morning. I am sure you are familiar with the report of the GAO and perhaps you have heard the testimony of representatives of the GAO. We will welcome whatever statement you would be kind enough to make.

PANEL TWO—THE FEDERAL RESPONSE: CONSISTING OF CAROLYNE DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY KEVIN MOLEY, SPECIAL, ASSISTANT, CHAIR OF HCFA'S TASK FORCE ON HMO/CMPS, AND FRANK SEUBOLD, PH.D., DIRECTOR, OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF CAROLYNE DAVIS

Ms. DAVIS. Thank you, Mr. Chairman.

I would like to just very briefly summarize our statement, which will appear in its total.

First of all, on my left, accompanying me is Mr. Kevin Moley, who is special assistant in my office and he is the Chairman of our HCFA Task Force on the HMO Competitive Medical Plans and its implementation.

I think it is important to remember that on April 1, we signed the first Medicare risk contract authorized by the TEFRA Act, and we expect over the next several years, obviously, there will be significant expansion. I think the contracts are very attractive for both the Medicare Program's point of view, as well as the beneficiaries.

First of all, they do offer an alternative to the traditional fee for service system. Second, they provide our beneficiaries with a choice and they offer additional benefits at a reduced cost.

Most importantly——

Mr. PEPPER. And they save the Government 5 percent of the average cost.

Ms. DAVIS. That is correct.

I think it is important that the beneficiaries have the right to immediately disenroll and rejoin the traditional fee-for-service Medicare system. We gained a lot of experience from our demonstration projects and particularly from those in the south Florida area that, frankly, enabled us to sign our first TEFRA contracts with a degree of confidence that we would not have had otherwise. We learned a great deal from those demonstrations.

It is also important to recognize that prior to 1979, our experience with the HMO's was primarily limited to cost contracts. In 1978, we submitted our first contract for risk and we had a very small number of plans at that point in time to develop under a risk basis. We conducted two other pilot tests. In 1979, we awarded 9 HMO's and in 1982, we awarded 23 demonstrations.

Now, what did we learn in our demonstrations? We learned that the HMO could predict their Medicare costs in advance, but they were able to offer additional benefits; that our beneficiaries were

attracted to enroll in those prepaid plans; and in fact, in 1984, we had approximately 300,000 beneficiaries who were enrolled; that most of our beneficiaries did understand and accept the lock-in requirement. and that they were, as a whole, satisfied with their prepayment plans.

The beneficiary choice was increased by having more than one plan in an area, and as you indicated earlier, that there was a 5 percent lower than payment for the fee-for-service.

When you do a demonstration, the purpose of a demonstration is to determine the feasibility, if you can implement it in a full-fledged implementation plan; and we did identify problems. We identified problems with timely enrollment and disenrollment procedures and we believe that we have corrected those.

We identified some problems with the beneficiary's understanding of the lock-in. We corrected those problems also. These problems have been addressed, either administratively or by change in our regulations.

Unfortunately, prior to the release of the report of March 8, the GAO did not obtain our comments from HCFA. I think if they had done that, Mr. Chairman, we might have avoided conveying the impression that the problems experienced in the demonstrations have been ignored or have not been corrected. This is simply not the case.

I would like to submit for the record our response to the GAO report at this time.

Mr. PEPPER. It will be incorporated in the record.

Ms. DAVIS. Thank you.

[The response referred to follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, April 23, 1985.

Hon. CHARLES A. BOWSHER,
Comptroller General of the United States,
Washington, DC.

DEAR MR. BOWSHER: In accordance with the requirements of OMB Circular A-50, I am enclosing the Department's comments on the General Accounting Office's report "Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida's GAO/HRD-85-48, dated March 8, 1985.

Sincerely,

MARGARET M. HECKLER, *Secretary.*

Enclosure.

REVIEW OF GAO REPORT ON SOUTH FLORIDA HMO DEMONSTRATIONS

SUMMARY GAO FINDINGS

The General Accounting Office (GAO) issued a report to Congressman Lawrence J. Smith on March 8, 1985 which indicated the following problems:

Enrollments and disenrollments of Medicare beneficiaries were not processed in a timely manner; HCFA's system for coordinating payments to physicians and hospitals was susceptible to errors; and Florida Blue Shield paid many part B physicians' claims in error.

SUMMARY HCFA STAFF FINDINGS

Staff found, contrary to GAO's findings, that HCFA's system for accounting for payments made by part A intermediaries for HMO members operated correctly in every case identified by GAO as an error. GAO's conclusion that this system is susceptible to error is not supported by any evidence.

Staff found that delays in posting beneficiary records did cause the contractor to make initial payment errors on seven cases paid by the part A intermediary. How-

ever, no duplicate payments were made on these cases. The delays in posting beneficiary records has been eliminated.

Staff examined a sample of 100 part B claims which GAO said Florida Blue Shield paid in error. We found that 17 of these cases were for beneficiaries who were not members of an HMO at the time services were delivered and that no payment error occurred. Payment errors were made on the remaining 83 cases. Errors were caused by two things: the computer system used by Blue Shield at the time did not perform to HCFA standards (this was corrected in May 1984) and delays in posting beneficiary records resulted in furnishing the contractor with incorrect information (as stated above, these delays no longer occur).

METHODOLOGY FOR GAO AUDIT

GAO identified 6,737 beneficiaries who had received services outside the HMO. This represented 6.4 percent of the beneficiaries enrolled in the HMOs. Physicians' billed charges for these cases amounted to $2.6 million. GAO said the part B carrier, Blue Shield of Florida, correctly denied $1.9 million in submitted charges and incorrectly processed to payment $700,000 in submitted charges.

GAO also studied 64 cases of the 6,737 on which the submitted charges denied exceeded $5,000. They attempted to determine if the claims had been transferred to the HMO for payment by examining files at the HMO. They could find only 60 percent of the "billed charges" at the HMO.

GAO also examined hospital bills applicable to the 64 beneficiaries with denied physicians' bills of more than $5,000. There were 55 inpatient hospital admissions for the 64 beneficiaries. The intermediary made payment for 44 admissions. GAO found that in one-fifth of the 44 cases, HCFA records did not show that the beneficiary was enrolled in an HMO at the time of the admission.

GAO also concluded from its review that: costs of hospital services authorized by the HMO were not correctly charged to the HMO by HCFA resulting in program overpayments; costs of hospital services not authorized by the HMO being charged to the HMO by HCFA resulted in program underpayments to the HMO, and that the HMO did not pay deductibles and coinsurance charges for services authorized by the HMO.

GAO RECOMMENDATIONS

The GAO report recommended that the Secretary should direct the Administrator of HCFA to act to identify and correct the systemic problems leading to the erroneous physician and hospital payments GAO found. Corrective action should center on overcoming the problems of intermediaries and carriers not knowing when beneficiaries are enrolled in HMOs because of the delays in recording enrollments and disenrollments and problems with computerized exchange of data among the Medicare paying agents, HMOs, and HCFA.

ANNOTATION OF BENEFICIARY MEDICARE RECORDS

Most errors identified in the GAO report were the result of delays in annotating beneficiaries' Medicare records to show that they were a member of a HMO. The GAO report accurately reflects (page 18) that beneficiaries' records were not annotated in a timely manner.

This is a problem of which HCFA had been aware for some time. Staff has, over the past year and one-half made several improvements which have eliminated this problem. Currently, there is NO DELAY in annotating beneficiaries' records when they join or disenroll from an HMO. On April 1, 1985 all records of Medicare beneficiaries who joined an HMO or who disenrolled from an HMO effective April 1 were annotated to show that status.

This schedule, of annotating records on the effective date of the enrollment/disenrollment, will be followed under the new HMO reimbursement provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

These improvements were planned and being implemented many months prior to the receipt of the GAO report. Our experience with the demonstration HMO contracts made us aware that improvements in the system would have to be made in order to implement the new TEFRA reimbursement provision.

Specific actions HCFA has taken to permit on-time annotation of beneficiary records are:

Rescheduling submission of actions by the HMO; improved internal scheduling at HCFA/SSA; development of a new on-line telecommunications system for HMOs to transmit pre-edited data to HCFA; intensified management oversight of computer

operations; and increased emphasis on contractor performance of activities related to HMO beneficiary claims.

DUPLICATE PAYMENTS FOR INPATIENT HOSPITAL CLAIMS

GAO studied 55 hospital admissions for Medicare HMO members. The intermediary had paid claims for 44 of the 55 and denied payment in 11 cases. GAO concluded that for 13 of the 44 admissions for which payment was made, HCFA failed to record the payment to collect the payment from the HMO. If this were correct, HCFA would have paid both the HMO and the hospital for the cost of 13 hospital admissions.

HCFA staff asked GAO to identify the cases cited and followed the cases through the HCFA processing system in Baltimore. We found that in ALL cases the processing system had (or will be) properly charged these hospital costs to the HMO.

We found that GAO auditors OVERLOOKED eight of the cases which were listed on HCFA's "bill itemization listing" (the report used to identify such payments for withholding of funds from the HMO). In three cases the bills were not on the listing because the bills contained a clerical error and had been returned to the intermediary for correction. When the bills are corrected and resubmitted to HCFA the computer will list the bill on the itemization report. In the other two cases, the bills are being held within the computer system awaiting the receipt of a prior outstanding hospital bill. This is because hospital bills must be processed in-sequence in order to administer the spell-of-illness provisions of the Medicare law. When the prior outstanding bill is received, the pending HMO hospital bill will be processed, and the payment will appear on the itemization listing.

CASES NOT "HANDLED CORRECTLY"

In commenting on the inpatient hospital claims studied (the 44 cases referred to previously), GAO said that 27 cases were "not handled correctly in all respects." Staff asked GAO to identify these cases so that corrective action could be taken. GAO furnished us with 26 cases, apparently the correct number rather than 27.

GAO had counted an error if it found any one of the following conditions present: HMO approved admission not found on HCFA's duplicate control "itemization listing"; admission not approved by HMO but admission reflected on "itemization listing"; admission not approved but intermediary paid claim; HMO did not have copy of paid bill where the intermediary paid the claim; and HCFA records did not show correct beneficiary HMO membership status at time of admission.

Staff revisited all 26 cases and found:

In no cases was a duplicate payment made because a claim paid by the contractor did not (or will not) appear on the "itemization listings."

HCFA records did not reflect the correct HMO membership status at the time of admissions for 7 of the 26 cases because of processing delays in posting beneficiary records. This problem has been resolved as discussed previously.

GAO incorrectly counted as "errors" 13 cases which it could not find on the "itemization listings." Staff found eight cases which GAO overlooked. Staff found three cases where the bills were returned for correction and will be processed to the itemization when resubmitted. Staff found two other cases which are pending in the computer system awaiting processing of an outstanding hospital bill and these will be processed to the itemization list upon receipt of the outstanding bill. GAO was incorrect in counting any of these cases as an error.

Staff could not determine if the contractor sent copies of paid bills to the HMO for the 25 cases on which GAO could not find a copy of the bill at the HMO. Staff did verify through a site visit to the contractor that it does routinely send such copies to HMOs when it makes a payment for an HMO beneficiary. Even if none were sent, this would not result in a payment error.

The contractor did incorrectly pay two of four cases where the HMO did not authorize the admission because of delays in updating beneficiary records in Baltimore.

In summary, no duplicate payments were made on any of the 16 cases. No payment error was made on 24 of the 26 cases which GAO counted as errors. Two cases were paid in error by the intermediary and the payments charged to the HMO. On these cases the HMO may challenge the payments and not be charged with the payments. GAO counted errors on 25 of the 26 because it could not find a copy of a paid bill at the HMO. Staff believes copies were sent because it has verified that the contractor does routinely send such copies to HMOs. The only errors in processing occurred on two cases and were caused by human error.

INCORRECT PAYMENT OF PART B CLAIMS BY CARRIER

The report said that GAO obtained a list of HMO enrollees from the HMOs. From the records of Florida Blue Shield they prepared a list of all part B claims paid by the contractor against this listing. They found that the contractor had paid 1,530 beneficiaries' claims improperly because the claims should have been transferred to the HMO and paid (or denied) by the HMO.

Staff requested a listing of these payments from GAO to determine the cause of the incorrect payments. However, the listing of incorrect payments was not received from GAO until April 10, 1985. The listing provided did not contain the dates the services were furnished, so staff could not do a thorough analysis of these payments. Staff obtained information on dates of service for a small sample (100 randomly selected) of these payments from the contractor.

Seventeen percent of the cases listed as errors by GAO were claims for beneficiaries who were not enrolled in an HMO at the time the service was received. These payments were not in error. Apparently GAO did not verify that the individuals were members of an HMO at the time of service.

The contractor paid 49 percent of the 100 cases in error because its computer system did not perform to HCFA specifications. That problem was corrected in May, 1984 and this cause of error has been eliminated.

The remaining 34 percent error was caused by delays in annotating beneficiaries records in Baltimore. This cause of error has been eliminated.

Summary findings for this sample were:

In 34 cases the beneficiaries' records were not annotated timely causing the errors; in 49 cases the error was caused by the contractor data processing system failing to perform to HCFA specifications; and in 17 cases there was no error because the date of service was not during a period of enrollment in "risk" HMO.

Staff discussed the cases where the contractor paid a claim in error because it did not follow procedures with the contractor. The cause of all such errors occurring prior to December, 1983 was that the computer system used by the contractor did not conform to existing procedural instructions. This problem was fully corrected effective May, 1984 and errors caused by the system did not occur after the date and should not occur in the future.

CORRECTIVE ACTION TAKEN REGARDING PART B PAYMENTS

The following actions have been taken to prevent incorrect payment of part B claims by contractors for HMO members during a period of enrollment in an HMO:

Beneficiary records in Baltimore are updated in a timely manner on the effective date of an enrollment.

Disenrollments are also recorded on the effective date unless HMO information is received in HCFA after the 26th day of the month. In this event, records are updated immediately upon receipt of disenrollment information from the HMO.

Any payments made by part B contractors for an HMO member during a period of enrollment are listed upon receipt of the payment information in Baltimore and furnished to the HCFA regional office for investigation and recovery of amounts paid, if appropriate.

All contractors' procedures for processing claims involving HMO members will be regularly reviewed against national performance standards and the results of this review included in contractor performance evaluations.

Effective June, 1985 HCFA will send a letter to each new risk HMO enrollee reminding that enrollee of the restriction on payment for non-emergency out-of-plan services.

ADEQUACY OF PROCEDURES CURRENTLY AND IN THE FUTURE

Staff believes that all procedures necessary to assure prompt and accurate handling of claims by contractors for beneficiary members of HMOs/CMPs are inplace and will assure that problems reported in the GAO report will not be repeated as the number of HMO/CMP contracts increase.

Our review found that controls to prevent duplicate payments are working, contrary to the findings reported by GAO. Annotation of beneficiary records, the key to proper claims processing, is currently done without delay and will continue to be done without delay. Contractor performance reviews are being intensified in the area of HMO beneficiary claims to prevent errors by contractors. Our letters to beneficiaries when they first join a risk HMO/CMP should serve to reduce the number of out-of-plan claims submitted to contractors for payment and reduce the potential for error. We have intensified training of HCFA regional staff to increase

closer oversight of contractors procedures for processing claims of HMO/CMP members. All procedures, not just those addressed in the GAO report, have been reviewed and we believe will assure correct handling of HMO/CMP claims.

DOCUMENTATION BY HCFA STAFF

Each of the findings of HCFA staff mentioned in this report is documented. Copies of this documentation are available for inspection by GAO or other authorized Government officials in the office of the Group Health Plan Operations Staff, Room 320 Meadows East Building, 6300 Security Blvd., Baltimore, Maryland 21207.

[Chairmen Pepper subsequently submitted the following General Accounting Office response to the HHS comments:]

U.S. GENERAL ACCOUNTING OFFICE,
Washington, DC, June 24, 1985.

Hon. CLAUDE PEPPER,
Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This is in reply to your May 8, 1985, letter asking me to respond to the Department of Health and Human Services' (HHS') comments on our report *Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida* (GAO/HRD-85-48, Mar. 8, 1985). HHS released its comments at the Subcommittee April 24, 1985, hearing on health maintenance organizations (HMOs) and Medicare at which I also testified.

HHS' comments involving payments for hospitals services

—misstated the findings and conclusions in the report and then commented on these misstatements rather than on what the report actually said;

—failed to recognize as payment errors situations in which the HMO did not pay beneficiaries cost-sharing amounts as they should have under the terms of their benefit packages; and

—incorrectly implied that we had not asked the Health Care Financing Administration (HCFA) to investigate cases in which we reported "potential program overpayments" for impatient hospital services.

We also believe that several HHS comments on that portion of the report dealing with erroneous physician payments for HMO enrollees are misleading. Moreover, after reexamining our computer program to better assure that all claims for potential out-of-plan services were identified, we found that we understated (1) the number of Medicare beneficiaries obtaining out-of-plan services, (2) the amount of claims correctly denied and (3) the amount of claims incorrectly allowed by the Medicare carrier.

DISAGREEMENTS WITH HHS COMMENTS RELATED TO PAYMENTS OF HOSPITAL BILLS

We disagree with the HHS comments on our findings and conclusions related to the coordination problems involving payment for hospital services in three areas:

—First, the HHS comments incorrectly assert that we had concluded that HCFA's system for preventing duplicate payments involving bills paid by Florida Blue Cross on behalf of HMO members was susceptible to error. Actually, our conclusion related to HCFA's system for responding to hospital admission notices and the related time lags between the effective dates of beneficiaries' enrollment in an HMO and the recording of such dates in the files used to make those responses.

—Second, the HHS comments do not recognize as payment errors situations in which the HMO did not pay the beneficiaries' cost-sharing amounts as they should have. HHS also incorrectly states that no payment error results when the intermediary fails to notify an HMO of a hospital payment made on behalf of its Medicare members.

—Third, the HHS comments incorrectly implied that before issuing our report, we did not work with HCFA officials to locate the HCFA records for 13 hospital admissions. HCFA says the search of its records showed that it recovered or will recover the payments from the HMOs for hosital services paid by Florida Blue Cross on the HMOs' behalf, but HHS' comments do not reveal that we asked HCFA to perform such a search on two occasions (Dec. 14, 1984, and Jan. 10, 1985), without success, before issuing our report.

What did GAO actually say regarding HCFA's system for preventing duplicate payments of hospital bills?

What we said regarding the procedure for controlling duplicate hospital claims was on page 19 of the report.

"Of the 44 admissions for which payment was made, 40 were authorized by the HMO and 4 were not. We located the payments for 31 admissions on HCFA's bill itemization lists to be deducted from the HMO's payments. [The itemization lists are HCFA's records on which such deductions are based.] *However, we could not find on the lists the payments for 13 admissions totaling about $74,700.* Whether the admissions were authorized by the HMO or not, these payments represent *potential program overpayments. If* they were authorized and not deducted from the HMO's capitation payments, they represent duplicate payments. *If* they were not authorized, they represent payments for noncovered services. *We have provided HCFA officials with a list of the payments we could not locate to see whether they could find them."* (Italics added.)

We had characterized the payments for the 13 admissions as *potential* program overpayments because we believed that as long as Florida Blue Cross had records that payments had been made, they were somewhere in the HCFA-intermediary data interchange system and might or might not eventually end up on the bill itemization lists.

As stated on pages 17 and 18 of the report, our problem with the procedure for controlling duplicate payments for hospital services.

> "is that the payment information furnished [to HCFA] by Florida Blue Cross does not show whether the bill was paid on behalf of the HMO (either as an authorized admission or an emergency), and this can result in the cost of services not authorized by the HMO being charged to it."

We believe that the existing process would be improved if the intermediary annotated those bills that it knowingly paid on behalf of HMOs. This would enable HCFA to identify any payments for unauthorized services for further review. In addition, such annotations would facilitate the identification of payments made on behalf of HMO members and facilitate their timely charging to the HMOs.

Rather then conclude that HHS had made duplicate payments because its system to prevent such payments was susceptible to error, our conclusion related to HCFA's system for responding to hospital admission notices for HMO members (see p. 23 of the report) and stated:

> "The time lags between the effective dates of enrollment and the recording of such data on the HCFA files *used to respond to hospital admission notices* made the system for coordinating the HMO's operations with the administrative structure for paying hospitals under the regular Medicare program vulnerable to error." (Italics added.)

The Department's comments acknowledge that the time lags shown on page 18 of the report are correct. As a consequence of these time lags, we reported that HCFA's responses to the hospital admission notices were incorrect in about 18 percent of the cases we analyzed. HCFA did not question this but stated that the improvements in the timely annotation of beneficiary records ". . . were planned and being implemented many months prior to the receipt of the GAO report." However, HHS' performance suggests that there might be some connection between our March 8 report and the elimination of the longstanding problem of time lags in recording enrollments on the HCFA files. During 1984 there was a time lag every month ranging from 16 to 37 days. The dramatic improvement after our report was issued is illustrated by the following information, which updates the table on page 18 of our report.

Enrollment effective dates	Florida beneficiaries enrolled	Dates posted	Timelags (days)
January 1, 1985	7,126	January 18, 1985	18
February 1, 1985	8,794	February 15, 1985	15
March 1, 1985	7,743	March 20, 1985	20
April 1, 1985	6,206	April 1, 1985	1
May 1, 1985	5,370	April 29, 1985	

Differences between GAO and HHS in recognizing "errors"

The Department's analyses of the payments involving hospital services counted as payment errors only those that involved Medicare overpayments and did not include situations in which the HMOs had not paid the beneficiaries' cost sharing amounts when they should have. We believe that when the Department contracts

with an organization and pays it to provide a specified benefit package that includes paying beneficiary cost-sharing amounts, it has an obligation to assure that such benefits are paid.

As stated on page 19 of our report, Florida Blue Cross had made payments for 44 admissions, and the HMOs had a record of 22 of them. When the HMOs had a record of the Blue Cross payment, they had paid related cost sharing amounts as required by their approved benefit packages. When the HMOs did not have a copy of a Blue Cross payment made for one of their members, any related cost sharing was *not* paid. HHS' comments stated that its staff had verified through a site visit that the intermediary routinely sent copies of the paid bills to the HMOs when it made a payment for an HMO beneficiary. HHS added, "Even if none were sent, this would not result in a payment error."

In our view, this comment fails to acknowledge the problem that we identified and would not provide much satisfaction to beneficiaries or providers who have not received payments to which they are entitled. We do not know whether the intermediary had failed to send copies of the paid bills to the HMOs (as provided in the HCFA instructions or whether the intermediary had sent the bills and the HMOs had lost them.

In any event, we believe that a solution to this coordination problem would be to require that the intermediaries obtain from the HMOs a receipt for those bills that are sent to HMOs. This would provide an audit trail to establish whether the intermediary or HMO is at fault for failing to send or retain necessary documentation. It would also provide some accountability to better assure that HMOs pay benefits in accordance with their contracts. We believe that this same solution also applies to the coordination problem involving denied claims for physicians' services discussed on page 13 of our report, but not addressed in HHS' comments.

GAO efforts to locate hospital bills involving potential duplicate payments

HHS' comments include the following statements, which incorrectly say that we had not attempted before the issuance of our report to work with HCFA to locate the HCFA records for 13 admissions.

> "HCFA staff asked GAO to identify the cases cited and followed the cases through the HCFA processing system in Baltimore. We found that in ALL cases the processing system had (or will be) properly charged these hospital costs to the HMO."
>
> "Had GAO asked HCFA staff to investigate these 13 cases, GAO would have been furnished this information."

Although we provided the information requested on March 20, 1985, it should be noted that we had previously furnished the cases we questioned on December 14, 1984, and January 10, 1985, to HCFA's Director of Group Health Plans Operations Staff, Bureau of Program Operations. At those times we had asked the HCFA staff to do essentially what it did after we issued our report—that is, to determine the status of these cases or inform us as to whether they had appeared on the bill itemization lists. In response to our inquiries, HCFA provided us on three occasions in January 1985 numerous computer printouts, but these did not show us where these bills were in the system or whether they had been included on the bill itemization lists.

HHS' erroneous statements that we failed to work with HCFA to resolve the questions about the 13 admissions and that therefore we "OVERLOOKED" that 8 of the claims had been resolved are, in our opinion, unfair and unwarranted. We base this belief on the extent of our efforts discussed above.

After HHS released its comments, we obtained the materials HCFA used to review the 13 cases. These materials showed the following with regard to the eight cases that HHS said were on the itemization lists.

—In two cases the amounts paid by Blue Cross were not on the itemization lists. (HCFA had provided us a record showing Blue Cross rejected the bills but they were subsequently paid and, at the time we inquired, still not on the itemization list.)

—In two cases the specific itemization list on which the payment appeared was never made available to us during our review because neither the HCFA staff nor the HMO could locate it for us.

—In four case, payments were on the itemization lists that we had available at the time of our review but we were not successful in finding them.

With respect to the five cases that HHS said "will be" on the itemization lists, there were time lags of 7 to 15 months between the dates Blue Cross paid them on behalf of the HMO and the date of the HHS comment (Apr. 23, 1985).

INCORRECT PAYMENT OF PART B CLAIMS BY CARRIER

On page 9 of our report, we stated that about 6 percent of the Medicare beneficiaries enrolled in the four South Florida HMO demonstration projects (6,737 out of the 105,067) had potentially gone out-of-plan to obtain medical services at some time during their enrollment period in the HMOs. We also reported that Florida Blue Shield, the Medicare carrier in Florida, had inappropriately paid 12,441 claim line items for such potential out-of-plan services. These 12,441 items represented about 29 percent of the 44,135 claim line items processed for such services. This information was based on a computer match of the enrollment data obtained from the four HMOs with the payment history records of Florida Blue Shield.

The HHS comments focused on the 12,441 claim line items we said were incorrectly paid by Blue Shield. The HCFA staff reviewed a random sample of 100 of the line items. From this review HHS concluded that

—49 of the 100 cases were paid in error because Blue Shield's computer system did not perform to HCFA specifications. HHS stated that this problem was corrected in May 1984. (We discussed this problem in the report and stated that the carrier told us it had been corrected.)

—34 of the 100 cases were paid in error because of delays in annotating beneficiaries' records in Baltimore to reflect the period of HMO membership. HHS said that this cause of error has been eliminated as of April 1985. (The delays in annotating records were the major problem in reimbursing physician services discussed in our report. As discussed earlier, over the last few months since our report, HCFA has annotated its records on time.)

—17 of the 100 cases were correctly paid by Blue Shield. Rather than Blue Shield making a payment error in these cases, HHS stated thats the HMO enrollment data on which we based our computer matches were incorrect. For these cases, HCFA determined that the beneficiaries involved were not active members of any of the HMOs at the time the services in question were provided. (See the following section for our discussion of this.)

The general thrust of the Department's comments is that by using the HMOs' enrollee records rather than the official HCFA records, we had overstated the magnitude of the incorrect payments made by Blue Shield, although they agreed with 83 percent of the erroneous payments we identified. As discussed later we found that our interim report understated the magnitude of this problem.

Accuracy of Department's comments

We reviewed the 17 cases in which HHS said payments were correct and generally found that the HCFA analysis was accurate. However, HHS' comments did not disclose that the 17 cases in which the HCFA staff concluded that our computer match based on the HOMs records was in error represented only about 3 percent of the total dollar value of the claim line items in HCFA's 100-case sample.

In addition, the Department's comments stated

"Staff requested a listing of these payments from GAO to determine the cause of the incorrect payments. However, the listing of the incorrect payments was not received from GAO until April 10, 1985."

Although the statement may be accurate from the perspective of the HCFA headquarters staff, the information was available to regional HCFA staff since November 1, 1984, when we furnished a 356-page listing of the incorrect payments to Florida Blue Shield and sent a copy of the transmittal letter to the HCFA representative at Blue Shield.

Reason for using HMO rather than HCFA records

As stated on page 6 of our report, the four HMOs provided us with computer tapes identifying each Medicare beneficiary who had enrolled from the project's initiation date through February 28, 1984, and the time periods when these individuals were enrolled. We had requested these computer tapes during entrance conferences with the four HMOs in February 1984. We received the computer tape listings between March and May 1984.

We matched these individuals and related enrollment data to the payment history records of Florida Blue Shield. We did this to determine how many claims it had received for these beneficiaries while they were enrolled in the HMOs and whether the claims has been paid or denied. We requested the Blue Shield records on May 24, 1984, and the carrier sent them to us on July 10. We completed this computer match early in August. We also requested and received the HCFA master record tapes of HMO enrollees in early September. We planned to match the HMO furnished membership data with the HCFA records to identify the extent of discrepancies, but about this time we also received the payment records from Florida Blue

Cross for those individuals receiving out-of-plan hospital services. To expedite the issuance of our report, we elected to give the analysis of the Blue Cross data priority over the matching of the HMO and HCFA enrollment records.

After issuing our report, we made our computer match comparing the HMO and HCFA membership records. As a result of this work, we learned three things.

—First, for about 90 percent of the 108,563 matched beneficiaries, the membership data contained on the HMO files, including enrollment and disenrollment dates, agreed with the HCFA records.

—Second, for about 5 percent of the beneficiaries, the HMO records did not agree with HCFA's membership data in one or more elements each as enrollment or disenrollment dates. Because HCFA's files are considered the official record, we have to assume the HMOs' files may have been in error. For the remaining 5 percent, the HMO's records may have been a more useful source than the HCFA files in analyzing the relative magnitude of the out-of-plan services problem. This results because some beneficiaries had claims denied by Florida Blue Shield because they were HMO enrollees but these persons do not show up on HCFA's enrollment records.

—Third, the overall results of our analysis of duplicate payments are about the same irrespective of whether the HMO's or HCFA records were compared with the Blue Shield payment records.

After reexamining our computer program to assure that all claims for out-of-plan services were identified, we found our report understated the problems of (a) the number of Medicare beneficiaries obtaining out-of-plan services, (b) the amount of such claims correctly denied and (c) the amounts of claims incorrectly allowed by the carrier.

A discussion of these matters follows:

GOA report understated amount of out-of-plan services and incorrect payment of part B claims by the carrier

Our March 8, 1985, report stated that 6,737 (or 6.4 percent) of the enrollees screened had potentially received out-of-plan services. However, after reexamining one of our computer programs to assure all claims for out-of-plan services were identified, we found that many beneficiaries had not been matched against the Florida Blue Shield payment history records. During our match of the HMO and HCFA enrollment records, we discovered this and modified the program. Using HCFA's enrollment data, 19 percent of the total beneficiaries screened had potentially received out-of-plan services while they were enrolled in the HMOs. Using the HMO's enrollment data, this figure is 16 percent.

Our understatement of beneficiaries receiving out-of-plan services also result in the amounts of the denied and allowed claims to be understated and the reported error rate of 29 percent to be overstated. The table on page 10 of the report showed that 12,441 line items, with allowed charges totaling $562,234, had been incorrectly paid. Using our revised computer program and HCFA's and the HMO's enrollment data increased these figures and decreased the resultant error as follows:

COMPUTER MATCH BASED ON ENROLLMENT RECORDS

	Number of line items [1]	Amounts	
		Billed	Allowed
HCFA:			
Claims denied	177,587	$9,472,402	(2)
Less apparent duplicate denials	34,314	$1,711,143	(2)
Adjusted total	143,273	$7,761,259	(2)
Claims allowed	29,822	$1,765,332	$1,332,047
Total	173,095	$9,526,591	
Error rate (percent)	17.2	18.5	
HMO:			
Claims denied	157,080	$8,345,761	(2)
Less apparent duplicate denials	31,018	$1,585,491	(2)
Adjusted total	126,062	$6,760,270	(2)
Claims allowed	32,039	$1,846,380	$1,388,538

COMPUTER MATCH BASED ON ENROLLMENT RECORDS—Continued

	Number of line items [1]	Amounts	
		Billed	Allowed
Total	158,101	$8,606,650	
Error rate (percent)	20.3	21.5	

[1] A line item represents a specific type of service, such as an office or hospital visit, each time it is claimed.
[2] Not applicable.

Therefore, the selection of a data source for enrollment information affects only the magnitude of the problem, not the problem itself.

On pages 11 and 12 of the report, we arrayed the denied part B claims by beneficiary to develop a distribution by the amount of the denials. The distribution showed that about half of the beneficiaries had out-of-plan denied claims amounting to $100 or less, which represented nearly 6 percent of the total value of potential out-of-plan service. Further, about 9 percent of the beneficiaries had denials or more than $1,000, representing about 66 percent of the total value of potential out-of-plan services. As shown in the following table using HCFA enrollment records, the percentage distribution of the amounts of potential out-of-plan services are virtually the same as we originally reported.

Part B amounts denied	Submitted charges on part B claims allowed				Submitted charges on part B allowed claims	
	Number of beneficiaries	Percent	Total amount denied [1]	Percent	Number of beneficiaries	Amount
1 to 100	7,714	44.7	$376,699	4.9	1,235	$303,424
101 to 500	6,185	35.9	1,459,121	18.8	1,108	333,869
501 to 1,000	1,521	8.8	1,071,215	13.8	372	147,682
1,001 to 5,000	1,633	9.5	3,354,851	43.2	448	302,785
Over 5,000	188	1.1	1,499,373	19.3	60	95,722
Subtotal	17,241	100.0	7,761,259	100.0	3,223	1,188,482
All out of plan claims paid	3,095		(2)		3,095	576,850
Total	20,336		7,761,259		6,318	1,765,332

[1] Totals eliminate apparent duplicate denials (e.g., claims received and denied more than once).
[2] Not applicable.

We appreciate this opportunity to respond to the Department's comments on our report. We are sending copies of this response to the Secretary of HHS and to Congressman Smith and the rest of the Florida delegation. We are also sending copies to the Chairman of the Senate Committees on Appropriations and Governmental Affairs and the House Committee on Appropriations and Government Operations because they also received the Department's April 23, 1985, comments on our report.

As stated in our testimony, we are continuing our work at the four Florida HMO's, and we will provide you copies of our final report on these efforts when it is issued.

Sincerely yours,

MICHAEL ZIMMERMAN,
Associate Director.

Ms. DAVIS. There were a number of other issues that were raised by the HMO demonstration projects. Some of those were resolved with a statute of provisions in the final TEFRA. For example, profitability was an issue. The final TEFRA regulations provide that the level of the profitability of an HMO or CNP that they can build into their adjusted community rate can be no higher than that of its private-sector enrollees.

Favorable selection was another concern and the final regulations do not permit health screening. The demonstration experience has also led us to develop a separate quality assurance mechanism. We have been working closely now with the HMO industry to develop the criteria and our goals are to begin a review process no later than October of this year in an enhanced quality review mechanism.

I am certain that there might be some other unforeseen problems that have a potential to arise any time you move to a brand new format, you do have that potential. That is why I created our internal task force and data work group and that force will continue in its oversight of this important program's activities.

I think, Mr. Chairman, that will summarize my statement. It might be useful if, before we got into testimony, we could also ask to have Mr. Seubold's because his, I think, will bear directly on my testimony, too.

[The prepared statement of Ms. Davis follows:]

PREPARED STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

I am pleased to be here today to discuss Medicare involvement with Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs). With me is Mr. Kevin Moley, a special assistant in my office who chairs HCFA's Task Force on HMOs/CMPs.

This hearing comes at a watershed point in Medicare's relationship with prepaid health plans. On April 1 we signed the first Medicare risk contract authorized by the Tax Equity and Fiscal Responsibility Act (TEFRA). We expect a significant expansion in the number of plans that seek Medicare contracts and the number of beneficiaries who enroll in these plans.

We consider these contracts attractive for both beneficiaries and the Medicare program. These plans offer our Medicare beneficiaries an alternative to the traditional fee-for-service, cost reimbursement system. These HMOs and CMPs provide our Medicare beneficiaries with a choice. Beneficiaries will be free to choose between what we believe will be an increasing number of HMOs and Competitive Medical Plans, and remaining within the traditional fee-for-service system. Incentives to join HMOs or CMPs will be the additional benefits these plans choose to provide over the standard Medicare package.

Most importantly, should Medicare beneficiaries for whatever reason become uncomfortable with their HMOs or Competitive Medical Plan, they have the right to immediately disenroll and rejoin the traditional fee-for-service Medicare system. We recognize the importance of the option to disenroll if beneficiaries so choose, as the great majority of Medicare beneficiaries who enroll in HMOs or CMPs will not have had prior experience in a prepaid health plan setting.

MEDICARE HMO DEMONSTRATIONS

The implementation of the TEFRA regulation would not have been possible without the extensive experience gained from our demonstration projects, particularly those in south Florida. The lessons HCFA learned from this experience enabled us to sign our first TEFRA contracts effective April 1, with a degree of confidence that otherwise would not have been possible.

Prior to 1979, Medicare's experience with HMOs was primarily limited to cost contracts with a small number of plans. Medicare's authority to contract with HMOs was not widely used primarily for two reasons: The Medicare cost payment methodology was incompatible with the HMO model of service delivery and HMOs did not know how to set a price for a Medicare benefit package because they could not predict utilization or service needs of the elderly. HCFA had not actively encouraged HMO enrollment because there were so few HMOs and little beneficiary interest.

In 1978 HCFA announced a demonstration program to develop prospective risk payment contract with prepaid plans. Under the demonstration, prepaid plans would bear the financial risk for providing the Medicare benefit package for a specific rate per Medicare enrollee that was agreed upon in advance.

Through these demonstrations, we would be able to find out whether our plan was feasible, whether there was sufficient information to operate the necessary components, how much it would cost, who would benefit and who would lose, and what approaches were effective. We were also able to determine what approaches did not work and had to be discarded or modified.

We conducted two pilot tests—in 1979, we awarded risk contracts to 8 HMOs in 5 areas of the country; in 1982, we awarded 23 demonstrations in 45 additional areas. Through these demonstrations and their evaluation we studied issues concerning HMO operations, Medicare beneficiary responses, and HCFA administration of the risk contracting program. Through our evaluation of the early HMO demonstrations we learned:

HMOs could predict their Medicare costs in advance.

Due to efficiencies, HMOs were able to offer extra benefits over the basic Medicare benefit package.

Beneficiaries were attracted to enroll in prepaid plans. By 1984, close to 300,000 beneficiaries had chosen the HMO alternative. The primary reasons for enrolling were expanded benefits and lower premiums.

Most beneficiaries understood and accepted the "lock-in" requirement. The "lock in" feature requires HMO members to use only services provided or authorized by the HMO except in the event of emergencies or urgently needed services. Overall, disenrollment due to dissatisfaction with the "lock-in" was less than 2 percent.

Beneficiary satisfaction with prepaid plans equalled or exceeded that of beneficiaries in the traditional fee-for-service setting. Disenrollment for all reasons was very low.

In areas where there was more than one plan, beneficiaries were offered a wide array of choices of extra benefits and arrangements to suit their needs.

A prospective rate, incorporating adjustments for age, sex, and county, could be developed that was 5 percent lower than average fee-for-service costs.

To be sure, the demonstrations were not without problems. Demonstration projects exist expressly for the purpose of determining the feasibility of fullfledged implementation and pointing out the pitfalls and problems which may occur. As problems surfaced and HCFA began to address them, GAO began its investigation in South Florida. Unfortunately, prior to releasing its report of March 8, GAO did not obtain comments from HCFA. Had it done so they might have avoided conveying the impression that the problems experienced in the demonstrations have either been ignored or not corrected. This is not the case.

For instance, problems centered largely on the question of whether we could enroll and disenroll beneficiaries on a timely basis. This was a critical question. As became evident in the demonstration projects, and as indicated by the GAO report, it became a serious problem. It was a problem which was essential for HCFA to solve before we signed our first TEFRA HMO contracts. I am pleased to report that this problem was solved and moreover the systems developed in response to the problem make it highly unlikely this problem could reoccur.

Another question the demonstration projects were intended to answer was whether or not Medicare beneficiaries would understand the "lock in" provision common to HMOs. The GAO report indicated, and we agree, that the great majority of beneficiaries do understand the "lock in" provision. This is encouraging, although we still believe there is a need for further education in this area.

TEFRA

These two questions, whether enrollment and disenrollment could be carried out on a timely basis, and whether Medicare beneficiaries understand the "lock in" provision, represent the kind of lessons HCFA learns from the experience of demonstration projects. There were a number of other issues raised by the HMO demonstration projects, some of which were resolved by the statute or provisions of the final TEFRA regulation. For example profitability was an important issue, specifically the question of whether it was appropriate for an HMO to be losing money on private sector enrollees while making money on Medicare enrollees. This question of subsidy was resolved in the statute. While this Administration does not believe profit to be a dirty word, we do believe it is totally inappropriate for public monies to be used to subsidize an HMO's or CMP's private sector business. Consequently, the final TEFRA regulation provided for an ACR, or adjusted community rate, which represents the premium the plan would charge for Medicare covered services using as a basis the rates it charges its non-Medicare enrollees. The level of profitability an HMO or CMP can build into the ACR may be no higher than that of its

private sector enrollees. Thus, if an HMO were to be losing money on its private sector enrollees, it would likewise be forced to lose money on its Medicare enrollees.

In another example, the initial demonstrations in Minnesota permitted health screening for its High Option benefit package. Our analysis of enrollees showed us that this resulted in favorable selection that could lead to unforeseen costs. As a result, health screening was not permitted in the final regulation.

Demonstration experience also led us to conclude that a separate quality assurance mechanism needed to be developed and implemented. I am pleased to report that we are developing a new system to monitor the quality of care provided under our TEFRA contracts. We have been working closely with the HMO industry to develop a review system which will emphasize quality of care. The industry has presented us with a proposal and we are in agreement on the broad outline. We will be developing criteria using physicians familiar with the HMO concept and operations to review HMO care, with the goal of beginning review no later than October of this year.

These have been examples of the kinds of problems brought to our attention by the demonstration projects. These problems have been resolved—either administratively or by changes and refinements to the statute or the final TEFRA regulation. We realize that although the demonstration projects were an invaluable tool in pointing out potential problems for TEFRA HMOs/CMPs, nonetheless, in an initiative this far reaching, unforeseen problems may still arise. For this reason, we have created a HCFA Task Force on HMO/CMPs as well as a HMO data workgroup drawn from components throughout our Agency. The work of this task force and data workgroup represent our commitment to continued oversight of this important program. I will be pleased to answer any questions you may have regarding the implementation of the TERFRA HMO/CMP regulation.

Mr. PEPPER. Dr. Seubold, we will be pleased to hear from you. You are Associate Director of Health Maintenance Organizations, Office of Health Maintenance Organizations, Public Health Service. We will be pleased to hear from you.

STATEMENT OF FRANK SEUBOLD

Mr. SEUBOLD. Thank you. I appreciate this opportunity to take part in this discussion of what I believe, with all the rest of you, is an extremely valuable new program.

With your permission, I will submit my formal testimony for the record——

Mr. PEPPER. Without objection, it will be received.

Mr. SEUBOLD [continuing]. And just give a few more remarks to highlight that.

I think it is important to state that it is no accident that this program now can be implemented on a nationwide basis. Back in 1972, when the Congress first authorized risk contracts for HMO's to care for Medicare beneficiaries, there were only about 40 or 50 HMO's in the country, enrolling about 4 million persons. Only 22 of these had more than 20,000 enrollees.

In good part, because this Congress passed the HMO Act of 1973, which supported the development of more HMO's, the industry has grown at an almost astounding rate and today, there are over 350 HMO's serving about 17 million persons.

Because of your interest, I will go aside for a moment. I just received a report from Dr. Paul Elwood at Interstudy, who does the authoritative annual census, and in calendar year 1984, HMO enrollment increased by 3.1 million persons. That is as big an increase in one year as the total enrollment that HMO's had achieved by the time the HMO initiative had started back in 1971. So the industry is moving and moving fast to be able to respond to this new challenge that has been presented to them; 263 of these

HMO's have met Federal standards of the HMO Act and are immediately eligible to enter into contracts with HCFA.

The interest in Federal qualification continues to increase. In fiscal year 1984, we received applications from 56 organizations, of which 38 were approved. In just the first half of fiscal year 1985, we have received 73 applications and 46 have been approved. So we are working at double the rate that we were in the past year.

This experience that we in the Public Health Service have gained in evaluating applications for HMO qualification and in monitoring those HMO's which have been approved is directly applicable to this new challenge of performing the analogous role with competitive medical plans. We are resolved to maintain the same standards of quality and timeliness that the HMO industry has come to expect of us.

To date, we have received nearly 400 requests for CNP application packages. Since we were allowed to receive them beginning the first of February, we have received 11 applications and two of these have been approved. The others are still in process, but we anticipate a substantial volume of work come summer.

With this, I will terminate my comments and be pleased to attempt to respond to any questions you may have.

[The prepared statement of Mr. Seubold follows:]

PREPARED STATEMENT OF FRANK SEUBOLD, PH.D., DIRECTOR, OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the Subcommittee, it is a pleasure to appear before you this morning to discuss the role of the Public Health Service in the program designed to provide Medicare beneficiaries with an opportunity to receive their health benefits from prepaid health care organizations. By enrolling in such organizations, Medicare beneficiaries have the advantages of an organized delivery system providing a comprehensive range of health services and continuity of care. Furthermore, beneficiaries will receive from many prepaid organizations a broader range of services than are covered under the traditional Medicare program. These advantages are expected to be very appealing to beneficiaries, particularly to those who do not have established physician relationships.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) amended the Social Security Act to permit eligible organizations to enter into contracts with the Health Care Financing Administration (HCFA) to provide prepaid health care to Medicare beneficiaries. The legislation establishes two categories of eligible organizations; federally qualified health maintenance organizations (HMO's) and competitive medical plans (CMP's). The Office of Health Maintenance Organizations in the Health Resources and Services Administration, Public Health Service, is responsible for determining whether an HMO or CMP is eligible to negotiate a contract with NCFA.

We believe that it is crucial that these organizations provide top quality medical care and be sufficiently fiscally sound to take the financial risk involved, since the success of this new program will in large part depend upon these factors. The Public Health Service has been qualifying HMO's since 1974, and over the years has gained considerable expertise in assessing the performance of prepaid health plans. It has developed successful processes for reviewing applicant for Federal qualification and monitoring approved organizations for continued compliance. We are applying this same expertise and utilizing comparable review and monitoring procedures to assess competitive medical plans, since CMP's are organizations which have many requirements identical or similar to federally qualified HMO's.

I would like to review briefly with you our plans to approve and monitor prepaid organizations serving Medicare beneficiaries. It will probably be useful to begin by mentioning some similarities and differences between HMO's and CMP's.

HMO's and CMP's provide a comprehensive set of health care services including hospitalization, physician services, laboratory, x-ray, and emergency care to enrolled members for a pre-determined, fixed fee. The health care services must be available

and accessible to all members and provided in a manner that guarantees continuity for care. These organizations must accept full financial responsibility for the cost of providing medical care and absorb the loss if actual costs exceed the amount collected through premiums. Eligible organizations must be fiscally sound and must assure that health plan members will continue to receive health services for which they have paid even if the health plan becomes insolvent. Finally, HMO's and HMO's must have quality assurance programs and systems for handling member grievances.

There are also several important differences between CMP's and federally qualified HMO's. Generally, CMP's have greater flexibility in how they are organized, in how they develop their benefits package, and in how they establish their premiums. CMP's are not required to provide as many benefits as qualified HMO's, and may charge deductibles and higher copayments for specific services. In addition, CMP's do not have access to employers through the "dual choice" provision, that portion of the Federal HMO law which requires certain employers to offer qualified HMO's.

However, both HMO's and CMP's which receive a Medicare contract under the TEFRA provisions are responsible for the entire Medicare benefit package—either through direct service provision or subcontract with other parties.

Entities desiring to become federally qualified HMO's or eligible CMP's must complete an application. Over the years, we have refined the application for federal qualification to make it more manageable for applicants and for our reviewers. Today, there are 263 federally qualified HMO's serving about 12 million people. In addition, we have developed and distributed to over 400 individuals and organizations a CMP application that fully addresses all eligibility requirements. We consider the application an effective evaluation tool, but fully expect it will be modified as we learn more about the variability of different models of CMP's. To date we have received 11 CMP applications and certified 2 eligible.

The HMO qualification and CMP eligibility applications require detailed information and back-up documentation in the following areas:

1. Legal requirements describing the organizational structure and contractual arrangements; 2. health services delivery systems; 3. financial standing; and 4. marketing plans and methods.

In addition, HMO's applying for federal qualification are required to provide specific information about their management.

Once a completed application is submitted, we use staff and consultant specialists to examine closely the information provided for each of these functional areas.

Consultant reviewers are highly qualified experts who manage or work for HMO's, and, together with our own staff, constitute a multidisciplinary team. Each specialist is responsible for reviewing the application to identify potential issues. The team participates in a site visit to validate and clarify information in the application. Following the site visit, a report is prepared which encompasses all relevant aspects of the HMO's or CMP's operations.

As an outcome of the process, an organization meeting all requirements is determined to be either a federally qualified HMO or an eligible CMP. Organizations failing to meet all requirements are denied certification or may receive an intent to deny. The latter is used when it judged that the barriers to qualification or eligibility can be resolved in a relatively short time period. The Health Care Financing Administration is then notified of our decision on the eligibility of an organization to enter into contract negotiations. Upon successful negotiation, a contract is signed between HCFA and the HMO or CMP, and the organization may begin to enroll Medicare beneficiaries.

We are also responsible for assuring that federally qualified HMO's and CMP's with Medicare contracts continue to comply with the organizational and operational requirements of Federal law and regulation.

Our compliance process has three primary functions:

Acquiring information about ongoing operations; analyzing the information; and taking corrective action, if needed.

The information that is collected is gathered from routine reports on costs, revenues, membership, and utilization; reports from State regulatory agencies; complaints received about the HMO or CMP; and reports from regional office and OHMO staff visits. Information on each HMO and CMP is analyzed for variances with legal and regulatory requirements, projected organizational goals, negotiated assurances, and industry norms. If warranted by the analysis, a formal process is followed for corrective action. Failure to make the necessary corrections leads to loss of eligibility and notification to HCFA. Any such organization that does not continue to comply with these requirements will no longer be eligible for a Medicare contract and will have its contract terminated.

Finally, the PHS assesses and monitors the quality assurance programs of federally qualified HMO's. With regard to the Medicare contracts, PHS reviews the internal processes of the plans that protect quality, and HCFA reviews the quality of health care provided to Medicare beneficiaries by HMO's and CMP's. Everyone involved in this program is well aware that assuring high quality health care is of utmost importance. For us, it is an integral part of the review of the health services delivery systems and of the ongoing monitoring. Added to the special HCFA activities, the quality of health care provided to Medicare beneficiaries is under continual scrutiny. It must remain the central focus of our efforts.

To assure the success of this new program, we are working closely with HCFA to share information and findings and avoid duplicating activities. Offering Medicare beneficiaries the advantages of prepaid health care is a major initiative of the Administration. The cooperative efforts of PHS and HCFA to make this program a reality and a success should ensure that Medicare beneficiaries will be satisfied participants in this new venture.

Mr. PEPPER. You will not make a separate statement?

Mr. MOLEY. No, I will not be, Senator.

Mr. PEPPER. Very well.

Dr. Davis, and Dr. Seubold, we are immensely pleased to have you here today. We will want to ask some questions.

Mr. Smith, you may proceed.

Mr. SMITH. Thank you very much, Mr. Chairman. I appreciate the opportunity again. Ms. Davis, it is nice to see you again.

You made a statement that you have, in fact, taken into account the problems which have arisen in the Florida demonstration projects and tried to correct them before going and proceeding ahead with the new regulations which open up nationwide all of these on a permanent, rather than demonstration basis. I call your attention to the HMO—to the GAO report, which I am sure you read. On page 23, where the memo prepared for your agency by employees of HCFA has been quoted extensively. Let me quote one portion—it is the third paragraph on the page. It is 2 years ago.

The current system has never been capable of making changes in the two files on the first day of the month, even for routine transactions. For any transaction containing an error, the recording of an enrollment or disenrollment typically takes two or three months.

Then let me go to page 18—call your attention to the lag time chart. It shows the effective dates; the number of people enrolled; the dates posted and the time lag. The memo that I just quoted from was over 2 years old.

In January 1984, there was a lag time of 35 days; there were 18,000 people enrolled that month. January 1985, less than half the people, 7,000, were enrolled and the time lag was 18 days. So with half the number of people, you had cut down the lag time to a little less than 3 weeks, but just 2 or 3 months before then, with half the number of people in October 1984, only 5 or 6 months ago, you had less than half the number of people, 7,790, and the lag time was 32 days.

Ms. Davis, these two things, a report issued for you by your own agency and this lag time chart, seem to me to contradict directly the statement that you made that you have taken into account all the problems in the demonstration projects and have now put in place systems which would be effective to prevent these problems in a system that is going to enroll 2 or 3 million people in the next year or two.

Now, would you mind showing me where I might be wrong in that?

Ms. DAVIS. Yes, I would be very happy to. If I can distribute for your perusal a copy of our reply to the GAO report.

As I indicated in my testimony, Mr. Smith, it is unfortunate that the GAO could not have, as they usually do, share with us a copy of their draft report because I think we would have cleared up a number of misconceptions at that point in time.

It is true that they quoted from a memo in the summer of 1984 which was a justification for our asking for a sole-source contract in order to test some of these system improvements that were needed as part of an internal control.

I am sure you will agree that in order to gain one's point, many times hyperbole is used and I think that was part of that particular memo that clearly we did need to move to implement a system control. That was the justification for that. We have been working since the summer of 1984 to clear that up.

We did bring in a system that was tested that did help to clarify some of the internal marks that occurred in the systems within the HMO's themselves. We then turned our attention to looking at what controls we needed in the intermediaries and those were clarified and cleared up, I believe, in May 1984.

Next, I think it is important to recognize that as of April 1, as the GAO itself indicated, we were able to post on the first day of the month, which is the date that we have intended to aim for, and that is the one which we will clearly continue to hold forth in the future. It took us time to get our systems organized to do that, but we have them in place now. They will function and we will be able to do that.

I would like to point out, also, that no contracts came alive until April 1. We had that in mind and we would not have proceeded to implement the TEFRA if we were not confident that we would have those systems in place at that point in time.

Mr. SMITH. Let me ask you about that because as soon as you made the statement a few minutes ago, I wrote it down. First TEFRA contract signed and apparently they have been. When was that?

Ms. DAVIS. That was a conversion as of April 1 of this year.

Mr. SMITH. Conversion from existing demonstration projects?

Ms. DAVIS. That is right.

Mr. SMITH. In my office, Ms. Davis, you said to me directly when I asked you about these problems and the fact that the resolution of those problems hadn't really taken place at that point in time, you said it would be at least 6 months until you signed the first contract, from the effective date of the regulations, not from the date we were sitting in my office. Effective date of regulations was February 1 and we are only a little over 2 months, so apparently you have accelerated this process greatly.

Ms. DAVIS. What I was speaking of in your office, Mr. Smith, was the timeframe to review new programs. As you will recall, we were talking about new ones at that point in time and I indicated that the review process was such that we would start accepting applications in April, and knowing what the review process would be, both through the Office of HMO's, as well as through us, that I estimat-

ed that it would take until probably June to bring new ones into the system.

So far, what we have on board are those that are from the TEFRA contracts that have been converted, the demonstrations.

Mr. SMITH. Who has converted so far, do you know?

Ms. DAVIS. I could provide a list. We have 27 that have converted to the risk contract.

Mr. SMITH. I would be interested if you could do that.

Ms. DAVIS. I will be happy to do that.

[Material had not been received at the time hearing went to press.]

Mr. SMITH. With your testimony now that on April 1 you began posting current, what is the backlog? Zero?

Ms. DAVIS. Zero.

Mr. SMITH. Would that mean, then, if my office in the district in Hollywood called up HCFA to get information about a particular HMO patient, that we wouldn't have to wait sometimes 30-some-odd days to get the retrieval of information out, as we did before?

Ms. DAVIS. Yes.

Mr. SMITH. So if tomorrow I asked my staff to check up on something, you could assure me that, barring any unforeseen circumstances, like your computer being down, which affects everybody, we should be able to retrieve information almost instantaneously.

Ms. DAVIS. That is correct.

Mr. SMITH. I am going to be happy to try and make sure that that is occurring because that was a particular source of consternation to all the congressional offices, besides the patients and their representatives themselves. My office sometimes took 30 days or more to get information back from you after we inquired about the status that a constituent had come to us complaining.

Ms. DAVIS. May I point out, Mr. Smith, I assume that you are referring, then, to queries to the enrollment/disenrollment activities of the HMO.

Mr. SMITH. Well, of course.

Ms. DAVIS. OK. Just wanted to clarify that that would be——

Mr. SMITH. What steps have been taken to improve the telecommunication system, the interfacing software between the intermediaries, the HMO's, your office, et cetera, which is one of the areas where there is extreme difficulty in people talking to one another on the same level.

Ms. DAVIS. I am going to ask Mr. Moley if he will answer that.

Mr. MOLEY. Yes, Congressman. As you quoted on page 23 of the GAO report, that was, in fact, a sole-source justification letter for what we call Compuserv, which is a company which provides some software which, in fact, are edit screens for enrollments and disenrollments. That was, in fact, a sole-source contract. We are in the process of letting a contract, a general type contract, which should be completed by June or July.

We have, in fact, however, the Compuserv system in place for those HMO's that want to use it, which provides us with on-line capability to communicate back and forth, as I said, on an on-line basis.

Mr. SMITH. The hyperbole that Ms. Davis referred to was your own hyperbole in trying to get a sole-source contract, correct?

Mr. MOLEY. We recognized the problem——
Mr. SMITH. Not the hyperbole of the GAO.
Mr. MOLEY. Indeed not.
Ms. DAVIS. No.
Mr. SMITH. If you needed more, it took you a long time to get that thing on line. You should have used a little bit more hyperbole.

Mr. MOLEY. We recognized the delays—the 16- to 37-day delays—as being a primary problem. As a matter of fact, many of the allegations, if not most of the allegations in the GAO report are in regard to enrollments and disenrollments and those problems were caused by those delays of 16 to 37 days. Consequently, we realized that it was essential in order to implement TEFRA that we have that problem corrected.

As Dr. Davis has indicated, we believe it is corrected. We annotated the master record file on April 1. We have assurances from SSA that they will be cooperating with us in the systems and scheduling changes we have made and that they will be able to continue that with our cooperation.

Mr. SMITH. That is my next question. SSA, what has been done to resolve the time lag in enrollment/disenrollment directly? It is their computers that are used, not yours, so what has been directly with them to make them more responsive to getting that information in and out?

Mr. MOLEY. They were primarily scheduling problems that we had, Congressman, and if I might mention, on page 22 of the GAO report, it quotes that "While the processing system had never been adequate because it had never operated on the schedule designed," and we believe that is the operative sentence. The fact of the matter is we are now operating on the schedule designed or the schedule that we feel is appropriate to be able to make those annotations to the master record file on the first of the month.

Mr. SMITH. Have you found a decrease, therefore, in the number of gray areas that were documented by the GAO representatives over here about the people who enroll and effective date and during that interim gray period, get sick and all of a sudden there is a disclaimer by everybody of responsibility and the other side, the gray area where people disenroll and the HMO keeps getting paid, but they go to a doctor because they think they are disenrolled. The doctor legitimately gives treatment, renders the bill, the bill comes back rejected, HMO patient, and then the patient is stuck with the bill and the HMO won't pay because they didn't authorize and the HMO got the monthly capitation? Is that going to be reduced significantly?

Mr. MOLEY. Indeed, Congressman. Specifically, we did a random sample of the 1,500 cases that were brought to our attention by GAO. We were only able to obtain the names of those recipients on by April 10. We did a random sample in Florida of 100 of those claims and discovered that a full 34 percent of them were due—errors were due to the delays in the posting system.

I might add, 49 percent were due—49 of the 100 random sample that we obtained—49 were due to errors in the computer system of our contractor, which had been corrected in May 1984. As you may know, the universe of problems brought to the committee's atten-

tion by the GAO concluded in February 1984. We, in fact, in cooperation with our contractor, corrected that computer system in May 1984.

The remaining 17 percent of errors alleged by the GAO, which we believe are mistaken, the methodology used by the GAO, which, in fact, did not result in an overpayment or duplicate payment.

Mr. SMITH. I understand, but I am more concerned about the enrollment/disenrollment directly and the time lag as a result. The duplicated payments are the disease, but the symptom—I am sorry—that is the symptom when you look at it, but the disease is the fact that the information is not timely-in, timely-out. Are we going to be able to expect that there is going to be timely-in, timely-out——

Ms. DAVIS. Yes, that is in the work plans at this point in time, that we will, from now on, meet our deadline of the first of the month for that.

Mr. SMITH. Isolating out—and you really shouldn't do it because this is a people program. You know, in the computer, it is numbers, but in real life, it is real people and they have major problems, some of which were documented here by the first panel, but isolating out those personal problems, the Government lost a lot of money by double payment and the like, and when you expand that program significantly, you are looking at many millions of more dollars. We are trying to save money like you are in the system.

Ms. DAVIS. Mr. Smith, I would like to correct one thing and that is, we did not lose a lot of money. We would have gone back and looked at the GAO material and I would like to point out that a number of the errors were in terms of their not being clear about our methodology. In the part A system, when we investigated those, we found that each one of them was an error in terms of the GAO's assumptions.

On the part B, there were some duplicate payments, but we have made corrections in that. Where they were overpaid, we have gone back and are instituting the collection process from those.

Mr. SMITH. So there has been some benefit to the GAO report?

Ms. DAVIS. These were activities that we already had underway.

Mr. SMITH. So there was no benefit to the GAO report?

Ms. DAVIS. From my point of view, I think that we already knew the problems that the GAO identified and were already on a course of correcting them. If you found it of some substantive value, I leave that to you.

Mr. SMITH. Well, I appreciate your candor. Let me just say that Mr. Fowler, who works for your agency, when requested by me for statistical data collected by your agency with reference to what is provided for me in this report, he couldn't give me any.

Now, in fact, at the hearing in Boca Raton, he said it was attached to his statement and it wasn't at all, for which he apologized and then never came up with the statistics. Now, if you can tell me where those statistics were that I obtained here, I would be much more satisfied with your answer that the GAO report was of no value to you. I think that is a rather negative way of viewing what we are all in the business to do, and that is providing quality programs for people and in this case, quality health care that saves

money to the Government by providing a program that gives that health care at less cost.

I find it a little bit disturbing that you should just offhandedly feel that it might have provided some benefit to me, but that it didn't provide any benefit to you because, in dealings with your office, I can tell you that my staff and a number of other staffs from congressional districts around the south Florida area couldn't obtain any information whatsoever. So I would hope that you would look at it in the light of the fact that we are trying to do the right thing for the people of the United States and the GAO plays an appropriate role in that.

Thank you, Mr. Chairman.

Mr. PEPPER. Thank you, Mr. Smith.

Dr. Davis, we have been disturbed, I think, by this question of the disenrollment proceedures. Have you now revised the procedures in such a way that you think the delay is cleared up? Would you explain that?

Ms. DAVIS. Yes, Mr. Chairman, we believe that by redoing our own systems controls internally that we can meet our deadline of the first of the month so that an individual who wishes to disenroll will be actually disenrolled as of that first date of the following month.

We also have additional systems controls that will allow for separate checks on that so that there will be no possibility that an individual would be dropped and not paid for by either the Medicare Program itself or appropriately, once they are enrolled in the HMO. There is one problem that we are aware of and that is one of the situations that was alluded to earlier in relationship to if an individual is in a hospital at the time of enrollment in the HMO. That is an area we have been in discussions with the Ways and Means Committee and their staff in terms of reaching a resolution to that.

Mr. PEPPER. Now, when the individual determines that he wishes to be disenrolled, he gives a notice to the HMO ordinarily?

Ms. DAVIS. That is correct.

Mr. PEPPER. You don't get a copy of that, do you?

Ms. DAVIS. No, we do not, sir.

Mr. PEPPER. So, your information about the desire of that individual to disenroll depends upon that information being furnished to you by the HMO?

Ms. DAVIS. That is correct at this point in time, however, if an individual beneficiary feels that in any way there has been a problem from their point of view, then we have other systems that clearly are available for them to notify us. We maintain an Office of Beneficiary Services in all of our carriers and in our intermediary offices. We also have our own Office of Beneficiary Services in each of our regional offices.

Mr. PEPPER. But if you don't get notice that an individual has made an effort to disenroll himself at a certain time, I don't see how you are going to police that to see to it that the disenrollment process is properly consummated.

Ms. DAVIS. It is up to the HMO themselves to send that notification.

Mr. PEPPER. That is what we are coming back to. Now, how can you assure that the HMO will acquaint you with the fact that elderly person A has given notice of a disenrollment which is supposed to be effective the first of the following month and they are going to—so that you can see to it that it is done? How can you see to it that it is done?

Ms. DAVIS. Well, Mr. Chairman, we would not be checking each one of those——

Mr. PEPPER. If the HMO doesn't notify you and the citizen doesn't notify you, you don't know that this——

Ms. DAVIS. It is the responsibility of the HMO to notify us, but I would point out that we do have an ability to do checks on the HMO in terms of whether or not it is handling its own responsibilities. We go onsite at times and actually check to see what is going on with their record system.

Mr. PEPPER. Do you have a tight requirement on the HMO that if they don't give you that notice promptly, they will suffer some sort of retribution from you?

Mr. MOLEY. No, Congressman, we do not at this time, but on the other hand, we do believe that it would not be in the HMO's interest to maintain someone on their records who, in fact, didn't want to be. I must say that that would probably come under the heading of an abuse of the marketplace that would reflect poorly on them in terms of competing for other beneficiaries into their plan.

We do not have a specific system other than what Dr. Davis just alluded to in terms of the beneficiary's ability to contact our regional office, an SSA office or our Office of Beneficiaries in the Central Office, or in the office of the contractors.

Mr. PEPPER. Do you maintain an office in Dade County?

Mr. MOLEY. I believe SSA does, Congressman. SSA does.

Mr. PEPPER. FSA, what is that?

Mr. MOLEY. Social Security Administration.

Mr. PEPPER. Oh, Social Security Administration. Well, it may be that the individual who wishes to disenroll should notify the appropriate Government agency at the same time he or she notifies the HMO, so that Medicare would be advised that she is expecting to be released from HMO at the first of the next month and, therefore, to come back on Medicare.

Ms. DAVIS. Mr. Chairman——

Mr. PEPPER. I am wondering—you see, if you leave this in the hands of the HMO entirely and you haven't got some way to check up behind it, if they are somehow or another delayed in getting it done, that is the individual floundering around without anybody being responsible for a big medical bill. I am wondering if we shouldn't establish within all the several communities a representative of the Government agency and it would be sufficient if they just file notice with the Government agency that they are disenrolling from the HMO. Of course, they should file a copy with the HMO to give them that information.

Mr. SMITH. Mr. Chairman——

Mr. PEPPER. Excuse me just a minute. That is the first thing.

The next thing is, have we cleared up—do you feel that you have satisfactorily cleared up the question of the uncertainty as to who is responsible during that period of disenrollment.

Who is going to pay the bill that will be incurred during that period?

Ms. DAVIS. As I indicated before, we are discussing one or two variations similar to what the GAO's recommendation was in relationship to if you were in the hospital at the time that you are enrolled. That seems to be the only time where there is some ability yet to be confused about that.

We are looking at that in relationship to the alternative ideas of either having the HMO assume the responsibility or, at the same time, thinking about the fact that one can disenroll during that period when they are in the hospital as to who would have the responsibility at that time. But I think it is important to recognize that the HMO is always liable for any of the collection—I mean, for any of the services that are pending up until the point when we actually disenroll them. So really, it is to the HMO's advantage, I would think, to disenroll from their own records as speedily as they can, because they know that that process must come to our central office for final termination.

Mr. PEPPER. Now, you know, all individuals are not lawyers. Even lawyers sometimes are delinquent in checking up on their own rights, as I know from experience. An individual can be lying in his or her bed in a hospital and having previously given notice of signing up with the HMO, and then, as he is supposed to become covered as of the first of the following month—well, understanding that, he says, "OK, the first of the month I am covered by HMO," but they will come back and say, "Oh, you didn't get our permission to stay in the hospital," and he is lying there sick. He doesn't think about, "I have got to give a formal notice, go hire a lawyer to prepare my notice to the HMO that I am going to stay on in the hospital." How can we protect that individual in that case?

Mr. MOLEY. Mr. Chairman, what we are talking about with the staff of the Health Subcommittee of Ways and Means is specifically that subject, and one of the tentative ideas or ways we feel that that problem can be eliminated would be, for instance, that person who, for instance, as I believe the GAO alluded to, would be in a coma, for instance, on the 28th of the month. They have previously signed an enrollment card or an enrollment form for the first of the month.

We would pay the hospital DRG for that hospitalization. And yet, the person would remain in the hospital and the DRG would remain the payment form until that person came out of the hospital, at which time the HMO would become liable for his coverage.

We would still pay the HMO the capitation fee for the whole month. On the other side of the coin, which is generally accepted practice in the group health insurance, the private system, on disenrollment, if a person had already indicated to the HMO that they intended to disenroll on the first of the month and likewise were hospitalized on the 28th, the HMO would remain responsible for payment of the hospital bill until the person came out of the hospital. Yet, they would not receive their capitation payment for that month.

It would be, in fact, a wash. We have not settled on that particular arrangement, but at the moment, we think it has a great deal of fairness and that it is recommended by the experience of the pri-

vate group health insurance business which operates in a similar fashion.

Mr. PEPPER. Are you going to propose, out of your experience and knowledge, a form of legislation that you recommend to the Ways and Means Committee?

Ms. DAVIS. We are discussing several alternatives with the Ways and Means Committee at this moment, Mr. Chairman.

Mr. PEPPER. You realize you must, Doctor. These are just ordinary people——

Ms. DAVIS. Yes.

Mr. PEPPER. Some of them are elderly and their minds are not too alert and you have to protect them against failures that you might expect them to be guilty of for themselves. I have one or two more questions, but I didn't mean to delay you so long.

Mr. SMITH. That is quite all right, Mr. Chairman. I just had a possible suggestion—I have to laugh because you keep making reference to what the GAO has said and done in here and then you are talking with the Health Ways and Means Subcommittee about doing the same thing, so obviously there has been some benefit in this little blue book and I am really amazed—I am also frankly of the opinion that if all of these things which you are doing now have come just at a time when we are having these hearings, coincidentally enough, and perhaps it was by virtue of some little motivation that this little blue book had, but in any event, one of the things that was documented was, in fact, this ability to try and shove the ball, not necessarily negatively, but I mean in reality.

"Well, they don't notify us, so we don't know," and, you know, "We don't hear about it; we can't cure the problem." Perhaps you might think about a triplicate enrollment form. That would be with two envelopes attached to it. On a government form, this is the way you have to do it. Fill it out; one stays with the enrollee; one goes to the HMO and one gets mailed to HCFA. So that everybody's records are the same from the first instance and the same thing with disenrollment. Triplicate disenrollment. One goes to the HMO; one goes to HCFA and one stays with the disenrollee so that everybody knows what everybody is doing.

It might cost a few pennies more. We are talking about lots of money; the average capitation is $232 a month in Miami. We are talking about 22 cents and maybe a dime for the printing with an envelope. I think that is a fairly cheap price to pay so that if, in fact, a month or two has gone by, the HMO, for some reason, whether by design or whether by negligence, had not forwarded the request for disenrollment, for instance, to HCFA, the person could call HCFA directly and say, "I haven't been disenrolled. What happened?" And HCFA says, "Well, we have your record. Here it is," rather than saying, "We don't even know who you are because we don't have anything from the HMO in which you are enrolled."

It seems to me that would be a heck of a lot easier when everybody is operating with the same information universe. Just a suggestion.

Ms. DAVIS. Mr. Smith, first of all, I was not really trying to shove the ball, as you say.

Mr. SMITH. I said not necessarily in negatively, but you didn't have any information so it is easy, then, to start doing that, to

passing it around and saying, "It is not our fault; it is there fault." What I am trying to do is close the circle so that nobody can say it is not their fault because everybody is operating from the same set of——

Ms. DAVIS. All I was attempting to indicate was that it was not a problem that we could determine and I think the idea of a solution to a potential problem is an interesting one that we can certainly pursue.

My comments in relationship to the GAO report, frankly, are related to the fact that we think it would have been of much more significant help if we had had the benefit to comment in order to clarify its accuracy before it was released in a draft format, as is the usual customary practice.

Mr. SMITH. Your people had a lot to do with the information that was gathered here, and I know the GAO consulted with your people regularly. It is not as if you weren't aware that this report was going on; was being investigated and being drafted; am I correct?

Ms. DAVIS. We were obviously aware of the fact that it was going on. However, I think that some of the assumptions that were embued in their report were incorrect, and had we had a copy, we could have clarified those.

Mr. SMITH. Thank you.

Thank you, Mr. Chairman.

Mr. PEPPER. Thank you.

Dr. Davis, just a question or two more. In view of the fact that the HMO quite naturally has to give approval to the expenditure of money for medical care, that means that somebody has got to approve all these requests for medical assistance. Now, I mentioned, you remember, earlier this morning about some people that came to see me in Miami the other day and the doctor who was with them and their friend, who came to see me, telling me that it took them an hour and a half before they could get permission to get into an emergency room at the hospital.

Then they said they couldn't get anybody to give clearance to get an ambulance. The former doctor said that he took him in his own—took the man in his own car and carried him to the place. Now, I am concerned about these services—somebody being available all the time. You may have an emergency. Suppose somebody has a heart attack at night in his home and if he can't get anybody, the fellow is off getting a cup of coffee or there is nobody to answer, he can't get anything, then he has to go to another hospital other than the one that the HMO would prescribe.

Now what supervision are you able to assert that keeps you in close contact with the quality of care? Now, I am for the HMO's. You know, I have bothered you many, many times to give these folks a chance and as I said here a while ago, I am for the institution of the HMO, but I want to be sure that they give good care to the people, all of them, in all instances.

Now, what is your mechanism to see to it that they do give good care?

Ms. DAVIS. Mr. Chairman, we really do appreciate your support for the HMO movement. It has been very vital as we have moved forward in that area and we appreciate that.

I think it is important to recognize that in that particular situation, we have standing regulations that clearly indicate to each and every one of our HMO's that they must provide for 24-hour emergency care services. There should have been no one who should have questioned that at all, and if you could give me the exact data in relationship to where that occurred, we will immediately start an active investigation on that.

In relationship to the quality of care, there are two areas and I would like to ask Mr. Seubold if he would comment in relationship to what they are doing with the overview of the quality of care and then I would like to also indicate that we have some ongoing discussions now with our peer review organizations which are the medical review units that are responsible for looking at the quality of care in hospitals and we are now talking with them in drafting the implementation criterion on how they will go about review for that part of the HMO's care.

Mr. SEUBOLD. Thank you.

We have had the same provisions for quality assurance——

Mr. PEPPER. For the record, Dr. Seubold is speaking. Go right ahead.

Mr. SEUBOLD. Thank you.

We have had, since the passage of the HMO Act back in 1973, the same criteria for quality assurance systems required of federally qualified HMO's and the same provision has been carried over into the competitive medical plans. What is involved is demonstration by the organization that it, in fact, has and uses a quality assurance system that involves peer review; that is supported by an information system that is adequate to provide a basis for this peer review; and that includes continuing medical education for the health care providers. This is looked at at the time of qualification and we have had a contract with an organization known as the National Committee for Quality Assurance, which has made random visits to HMO's to assure how these systems continue to operate.

Mr. PEPPER. Dr. Seubold, you heard the testimony of these witnesses here this morning where it took 7 months to get a lady back on the Medicare Program and other delays. It took 7 days or something, 4 or 5 days, before a man could be sent to Jackson Memorial Hospital where the only medical skill was available to treat that particular case and the man died.

Why did it take 4 or 5 days to find out that the place they ought to send that man to is Jackson Memorial Hospital?

Mr. SEUBOLD. One of the principles upon which we operate is that the chief decider in terms of medical necessity is the physician and that what we insist on as part of our responsibilities is that the HMO has, through its medical staff, an operational system to review the care that is provided by those practitioners.

Now, the other side of this particular quality coin is provided by the authority under the peer review organization's statute, which is adminstered by HCFA and which, as Dr. Davis pointed out a short time ago, is moving ahead into——

Mr. PEPPER. Excuse me. Suppose that somebody in my community has a complaint. Now what can he or she do to get review of that complaint?

Mr. SEUBOLD. The first item that comes into that is that we endeavor to put the individual together with the medical director and/or——

Mr. PEPPER. But to whom does that individual—with whom does he make contact? Have you got somebody in Dade County?

Mr. SEUBOLD. No, sir. The——

Mr. PEPPER. Well, what is that individual going to do? How is he going to find you?

Mr. SEUBOLD. The first thing—that is another requirement for the HMO's—is that they must all have a formal grievance procedure to give access to enrollees to that system to endeavor to work out the problems. They are always entitled to complain, if they will, to our office or to the HCFA office.

Mr. PEPPER. I am not satisfied with that myself because human nature is what it is. Every time that—you know that those people that give permission have been instructed by their superiors to be discreet in the permissions that you give because it costs us money every time you give a permission. Obviously they are not going to just let everybody that has got a bad cold go to the hospital and the like, but the Government of the United States is the protector of the people, and from what you are all saying, there isn't anybody that this individual can appeal to except the company, the HMO that has already, in his opinion, denied him what he should have had.

I want him to have access to somebody who has no financial interest in it to review his complaint to see if it is justified or not.

Mr. SEUBOLD. There is a formal HCFA procedure under Medicare which provides rights of appeal for all Medicare beneficiaries according to well laid out statutes, regulatory provisions.

Mr. PEPPER. How do you appeal?

Ms. DAVIS. You would appeal in terms of the normal Medicare process by contacting one of——

Mr. PEPPER. Now, this is HMO we are talking about.

Ms. DAVIS. Well, that is right, but as Mr. Seubold was indicating, they would actually have two choices of appeal if they were in an HMO. They could either appeal through the HMO's appeal process, because each HMO does have to have their own internal appeal process or grievance process, and it is my understanding that some individuals do do that. If, on the other hand, as you indicated, they felt some degree of restriction and didn't wish to do that, then they have the right to appeal through the regular Medicare process, just as any Medicare beneficiary does, in which case they can contact our Office of Beneficiary Services——

Mr. PEPPER. Excuse me, Doctor. Now, that is Medicare.

Ms. DAVIS. Yes.

Mr. PEPPER. They are not complaining about Medicare having failed to do something they should have done; he is complaining about his HMO not having done something it should have done and I am wondering to whom he may go for redress.

Ms. DAVIS. But since Medicare gives a contract to the HMO, what I am indicating, sir, is that if they feel constrained from appealing to the HMO itself, that they have an alternative. They can use the regular beneficiaries appeal process. We would handle that that way.

Mr. PEPPER. You heard me say a while ago, I want to see the HMO expanded. I think it is a wonderful contribution to a better health system than we now have. It is growing so rapidly, I would respectfully suggest to you that you consider having somewhere, centrally located, somebody to whom this citizen who claims that in the critical matter of his or her life or health has not had what he is due to get from his HMO, some impartial public authority will evaluate his complaint to see if it has any merit, and besides that, we all are human. We all have to sort of—our bosses always keep a look on us. Our constituents keep us under supervision because they want us to do a good job for them, and that is just human nature, that you like to take advantage of your privileges if you don't have anybody checking up on you.

I would respectfully urge that you develop a system, especially if you are going to expand, as I hope you are, so that the citizen will have protection in his home community and if they turn him down, he can go to these folks and say, "This is what they did to me."

I want you to check into it.

Ms. DAVIS. I would be happy to check into it, sir, and I would be happy to submit for the record a clarification of how the process does work at this point.

Mr. PEPPER. Well, I beg your pardon, Mr. Wortley, I am sorry to have taken so much of your time. We would be pleased to have you ask any questions.

Mr. WORTLEY. Dr. Davis, what was the timeframe that this data was all drawn from? Was it over a 2-year period?

Ms. DAVIS. The GAO report data started with the implementation of the demonstrations in the south Florida area and concluded in February of 1984. That was the timeframe under which their data was collected.

Mr. WORTLEY. So actually it ran over a period of about 2 years.

Ms. DAVIS. Yes. Eighteen months or so.

Mr. WORTLEY. Eighteen months.

Anytime during that period, did they contact you and ask you if any of the problems that they perceived had been corrected in any way? What current procedures you were then undergoing? Obviously, in a demonstration project, you are always revamping the procedures to smooth it out. Am I correct?

Ms. DAVIS. That is correct. That is obviously the purpose of why we do a demonstration, to learn. We always do learn from demonstrations and I tried in my testimony to highlight some of the things that we had learned. In relationship to our contacts with the GAO, I think our contacts were related to providing the data for that.

At no point, once they had that data and sat down to write the report, do I know of any final contact with our staff where it is the usual custom where they would send us a draft, ask us to comment and then revise it accordingly after we have had a chance to look at it, indicate where, perhaps, because of misunderstandings in methodology. There were changes that could be made to improve the process, and in particular, where there were claims that we were having significant overpayments.

I think we would have appreciated the opportunity to clarify that, since it didn't happen.

Mr. WORTLEY. In other words, the General Accounting Office was analyzing your pilot program, which you are always attempting to improve, and they never came back to you at any time and asked you if any new procedures had been initiated to improve——

Ms. DAVIS. I think their timeframe under which they wrote the report was restricted to end in February 1984, but as I heard in their testimony today, they clearly have been back since then to discuss with us what has happened since then because I heard them acknowledge this morning that they recognized that we have made significant improvements and that our system is on a timely basis. So I think we are in contact with them now.

It was simply that the printed word doesn't match where we are at this point in time.

Mr. WORTLEY. When I listened to their report, I thought it was kind of a fair and balanced presentation. It seems that it isn't as fair and balanced as I might have expected it to be.

Ms. DAVIS. I think because it was a snapshot that ended in February 1984 and did have some methodology of problems in it, that is why I asked, and the chairman acceded to our having a copy of our response to that GAO draft submitted for the record because it will clarify those points.

Mr. WORTLEY. Have your past experiences with GAO evaluations always reflected the lack of communications that existed in this particular case?

Ms. DAVIS. It is usually the process whereby we are in constant communications and they provide us with the ability to comment before they write that, but that depends totally upon what their assignments are, I suspect.

Mr. WORTLEY. You suspect their assignment was somewhat different than has been the case in previous instances?

Ms. DAVIS. Well, I can't conjecture on that.

Mr. WORTLEY. Certainly there was a large void in the communications and I would expect it was their responsibility to get back to you to find out where you stood.

Thank you.

Mr. PEPPER. Thank you.

Mr. Boehlert.

Mr. BOEHLERT. Thank you, Mr. Chairman.

Dr. Davis, first of all, I like your style. I think you are candid and direct and I think candor and directness is called for in this situation. I don't view this as an adversarial relationship. I think we are all in it together. We are trying to make the system work and——

Ms. DAVIS. I agree.

Mr. BOEHLERT [continuing]. I appreciate the chairman's enthusiasm for HMO.

You said this morning—that you have some rules governing HMO's that don't fulfill their contractual obligations. Perhaps the classic example would be to refuse to provide that the contract calls for. One, how do you identify these problems; two, when you identify them, what do you do about them? What punishment? Which penalty? I guess the bottom line is, do you have any examples?

Ms. DAVIS. In relationship to how do we identify them, we identify them from a number of sources. We can identify them—if it is a problem that is in an allegation from a beneficiary's point of view that we have heard about, either because somebody has written to us, they contacted the Office of Beneficiary Services or perhaps Social Security office or even sometimes they contact the Office of Beneficiary Services at the carrier level.

When we hear about those that are potential for abuses, we begin to investigate them. We have had several cases when we actually did that. We have sent our own staff in on site to look to see whether or not there were appropriate controls on the admission—I mean, on the enrollment/disenrollment process.

We have had a couple of occasions when we have actually asked the inspector general to go in when we felt that there was some potential abuses of the marketing and that there could have potentially been individuals who were enrolled that were confused and that we felt the marketing practices were not as clear as they could be.

We have required——

Mr. BOEHLERT. The followthrough is what I am really interested in.

Ms. DAVIS. We have required them to disenroll those individuals if it is a questionable practice in terms of marketing. Then we take back the capitation funds that we were paying them.

If it is a question of a quality-of-care problem, that obviously, is one of the areas where we work closely with Mr. Seubold's office and, as he indicated, they have gone in recently and have done some reviews of the quality of care. In some cases, we have required jointly corrective action plans to be submitted to correct something. Primarily they were problems in terms of keeping the top-level management aware of what was going on when the quality controls were being done.

That seemed to be the most consistent problem, but perhaps Mr. Seubold would care to elaborate on what they did find in their quality reviews. Then, as I indicated, we are concerned enough about the need to expand in this area of quality control that we began talking with our peer review organizations in January and have been working with the peer review organizations, the AMA, the HMO communities, the beneficiary groups, to structure a more structured quality review process that we will implement.

Mr. BOEHLERT. Have you actually penalized any HMO? Have you really imposed some degree of punishment on them?

Ms. DAVIS. Well, I would say that when you take action to tell them that they have to disenroll individuals and you take the capitation funds away from them, yes, that is a penalty.

Mr. BOEHLERT. Could we have some specific examples?

Ms. DAVIS. Yes, we can submit some of those for the record.

[Material had not been received at the time hearing went to press.]

Mr. BOEHLERT. My concern is that an HMO just might not fulfill its contractual obligation and there will be an innocent victim. The individual who is covered under the HMO perhaps is not even aware. They say "No," and they say, well, they view the HMO as being very official, so "it is unfortunate I can't have this service,"

when, in fact, the person should have that service. I just think so many of these examples probably don't come to your attention. That is why I share the chairman's concern.

How do we make it easier for people that have a problem like this to get their problem to your attention so that, No. 1, you can guarantee that they get the service that is bought and paid for; and No. 2, so that you can take corrective action to make certain in the future the HMO does fulfill its contractual obligations.

Mr. SMITH. Mr. Chairman, we have a vote on. I don't want to cut Mr. Boehlert short, but all of us are going to be late. Would it be permissible to have written questions that we may not have had time to ask submitted for the record?

Mr. PEPPER. Yes; submit your questions and they will be submitted.

Mr. SMITH. Thank you.

[The information follows:]

HEALTH CARE FINANCING ADMINISTRATION,
Washington, DC, June 5, 1985.

Hon. CLAUDE PEPPER,
Chairman, Select Committee on Aging, Subcommittee on Health and Long-Term Care, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Enclosed are my responses to additional questions following the April 24 hearing on "Health Maintenance Organizations and Medicare: Problems in the Oversight of a Promising Partnership."

Please let me know if I can provide any further information.

Sincerely yours,

CAROLYNE K. DAVIS, PH.D.

Enclosure.

QUESTIONS SUBMITTED FOR THE RECORD BY CONGRESSMAN CLAUDE PEPPER

Question 1. In light of Secretary Heckler's projections of an additional 500,000 Medicare beneficiaries opting membership in HMOs by the end of this year, what additional resources in terms of budget and staff is HCFA planning for its oversight of Medicare participating HMOs in FY 1986?

Answer. The new HMO contract provisions authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) became effective on April 1 of this year. Based on our activity to date, we project that Medicare enrollment in HMOs will increase by approximately 40 percent (150,000) this year. We expect a larger number of enrollments in FY 1986 and 1987—perhaps as many as 500,000 in those 2 years.

This increase was taken into consideration in development of the FY 1986 budget. No additional resources were requested for general administrative oversight since much of the contract administration responsibility has been delegated to our regional offices and the increased workload can be handled within existing budget and staff levels. However, within our available resources we will allocate additional effort to PRO oversight of HMOs.

Question 2. How many site visits were made by HCFA staff to Medicare participating HMOs in Fiscal Years 1984 and 1985?

Answer. HCFA staff made 65 site visits to Medicare participating HMOs in FY 1984 and 46 visits to date in FY 1985.

Question 3. On page 105 of HCFA's "Justification of Appropriation Estimates for Committee on Appropriations: Fiscal Year 1986," a reduction of some 34 percent in HCFA's audit workload for "other" providers (which includes HMOs) for FY 1986 is projected. What will be the audit workload for HMOs specifically, in FY 1986. How does this differ from the FY 1985 workload for HMOs? If the projection for FY 1986 does represent a reduction, what is HCFA's justification for this in light of the statement on page 102 of this same document: ". . . and the new emphasis on HMOs and their rapid growth also requires an extensive audit effort?"

Answer. HCFA's budget includes an increase in the level of audit of cost contractors in FY 1986. In FY 1985, we plan to spend $400,000 to audit 40 HMOs receiving cost reimbursement. This represents 56 percent of all cost HMOs. In FY 1986, our

proposed budget for auditing cost HMOs would increase 17 percent, to $469,000, to audit 45 cost HMOs (63 percent of all cost HMOs).

While we project a significant increase in HMO/CMP contracts in FY 1986, we anticipate this increase will be for risk contracts. We expect the number of cost contracts to remain constant. Risk contractors receive set payments in advance for each Medicare enrollee. Audits of actual costs incurred will not be required of these risk contractors. HCFA will monitor the operations of these HMO/CMP contractors to assure they are operating in compliance with Medicare requirements.

QUESTIONS SUBMITTED FOR THE RECORD BY CONGRESSMAN LAWRENCE J. SMITH

Question 1. Have you ever investigated the case of Louis Sposa of Plantation, Florida and the problems he encountered at a Broward County Health Maintenance Organziation? If so, what is the status of this investigation and what are your findings? Did you discover any mismanagement in this case? If so, have you taken any steps to assess penalties to the responsible parties? If wrongdoing was found, what steps does HCFA plan to take to prevent other similar incidents from occurring in the future? If you have not investigated this case, I request that you undertake such an investigation as soon as possible.

Answer. We requested International Medical Centers (IMC), the HMO where Mr. Sposa was enrolled, to conduct a quality assurance review of his case and prepare a report. We also requested the PRO in the area to investigate this case. While we have received the results of IMC's investigation, we are still waiting for the results of the PRO investigation. The report from the IMC Quality Assurance Review Board revealed that there was a delay in transferring Mr. Sposa from one hospital to another as a result of a Medciare coverage question but that this action did not result in a delay in proper treatment. We have assured that IMC has initiated new procedures to prevent further problems when Medicare coverage questions arise. Our review of the IMC report indicates that the medical procedures were appropriate. However, until we get the results of the PRO investigation, we cannot make a final determination. We will inform you if the PRO findings significantly alter our preliminary conclusions.

Question 2. Have you ever contracted with the NCQA or any other organization to do a study on the quality of health care provided by health maintenance organizations as a whole or any or all of those participating in the HMO/Medicare demonstration projects? Has HCFA or HHS or any of its offices or divisions ever conducted such a study? What were the results of this study? What steps have been taken as a result of such study to ensure that HMOs participating in the HMO/Medicare partnership provide quality health care? If no such study has been undertaken, why not? If such a study has been done, please include a copy.

Answer. The Office of Health Maintenance Organizations in the Public Health Service monitors the programs of Health Maintenace Organizations (HMOs) that are Federally qualified under title XIII of the Public Health Service Act. Their review of quality assurance programs is conducted through a contract with the National Committee for Quality Assurance (NCQA). During 1984, NCQA reviewed all five demonstrations projects in South Florida.

A number of problems were identified in the 1984 reviews and corrective action plans were developed by the HMOs. In addition, the Public Health Service conducted site visits to each of the HMOs to review their upgraded quality assurance systems. Three of the HMOs have been found to be in compliance—International Medical Centers, Florida Group Health, Inc., and Health Care of Broward Inc. Decisions are pending on Comprehensive American Care and Av-Med. Technical assistance will be provided, if necessary, to bring these plans into compliance.

In addition, HCFA currently has a contract with Mathematica Policy Research to evaluate a broad spectrum of issues relating to the Medicare competition demonstrations, including quality of care. Under this evaluation, several techniques will be used to assess quality of care, including a survey of beneficiaries, case studies, and an analysis of care in the demonstrations compared to national norms.

As a result of the demonstration experience, we are developing a separate quality assurance mechanism for our Medicare risk contracts under the Tax Equity and Fiscal Responsibility Act. We have been working with the HMO industry to develop criteria that will be used in a quality assurance monitoring system, with the goal of beginning reviews no later than October of this year.

Mr. PEPPER. Dr. Davis and Dr. Seubold.

Ms. DAVIS. I share your concern and we will look into that.

Mr. PEPPER. The record will be open for 2 weeks.

Thank you very much, Dr. Davis. Thank you, Dr. Seubold, for being with us today.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Honorable
Lawrence J. Smith
House Of Representatives

Problems In Administering Medicare's Health Maintenance Organization Demonstration Projects In Florida

In February 1985, the Department of Health and Human Services initiated a program to expand the use of health maintenance organizations (HMOs) by Medicare beneficiaries. This new program was preceded by 26 demonstration projects throughout the country to test HMOs' effectiveness. Four of the demonstration projects, involving about half of all Medicare beneficiaries in such projects, were started in south Florida. Because of beneficiary complaints and concerns regarding those HMOs, GAO was asked to review them.

GAO found the system for coordinating HMO and Medicare payments to physicians and hospitals susceptible to errors, such as Medicare paying for services that an HMO had already been paid for. Many errors GAO identified occurred because beneficiary HMO enrollment dates were not recorded until after the actions became effective. This led to incorrect determinations as to who should pay medical expenses--the HMO or the regular Medicare program. GAO recommends that HHS correct problems resulting in erroneous payments because of the program's expansion nationwide.

GAO also identified a relatively small number of beneficiaries for whom reimbursement of medical expenses was uncertain because they were transitioning into or out of HMOs. During such periods, it is not always clear who is responsible for paying medical expenses--the beneficiary, the HMO, or Medicare. GAO is continuing to assess the magnitude and specific causes of the transitioning problems. In a follow-on report, GAO will address this and the remaining questions it was asked to pursue.

GAO/HRD-85-48
MARCH 8, 1985

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-217802

The Honorable Lawrence J. Smith
House of Representatives

Dear Mr. Smith:

This interim report responds to your January 30, 1984, request that we review four health maintenance organizations operating under contracts with the Health Care Financing Administration as demonstration projects in Florida. This review is being made to respond to a number of questions arising from beneficiary inquiries and complaints received by your office.

As agreed with your office, unless you publicly announce the report's contents earlier, no further distribution will be made until 7 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

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GENERAL ACCOUNTING OFFICE
REPORT TO THE HONORABLE
LAWRENCE J. SMITH
HOUSE OF REPRESENTATIVES

PROBLEMS IN ADMINISTERING MEDICARE'S HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION PROJECTS IN FLORIDA

D I G E S T

In 1982 and 1983 the Department of Health and Human Services (HHS) awarded demonstration contracts to 26 organizations to develop health maintenance organizations (HMOs) for Medicare beneficiaries in 21 cities across the country. Four of the 26 HMO demonstration projects started in the Miami, Florida, area. As of October 1984 these four projects enrolled about 112,000 Medicare beneficiaries. This report focuses on selected administrative aspects of these four projects.

In February 1985 HHS initiated a nationwide program providing for the expanded use of HMOs by Medicare. Unlike most previous Medicare arrangements with HMO-type organizations, these demonstrations and the HMOs that will be created under the nationwide program (1) put the HMOs "at-risk" by paying them fixed amounts based on the average Medicare costs for all beneficiaries in the HMOs' service areas and (2) required that except for "emergency or urgently needed services," all health care for beneficiaries that enrolled must be provided or authorized by the HMOs. This latter feature is referred to as the "lock-in" provision, and any related services obtained by beneficiaries without the HMOs' authorization are referred to as "out-of-plan."

Neither the HMOs nor the regular Medicare program is supposed to pay for out-of-plan services. Beneficiaries are liable for associated costs.

In January 1984, Representative Lawrence J. Smith requested GAO to review the operations of the Florida HMO demonstration projects. The request was in response to beneficiary inquiries and complaints concerning the HMOs. Later, other members of the Florida congressional delegation also asked GAO to review the HMOs.

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As GAO's work progressed, it learned that most complaints and concerns focused on (1) the timely recording of the enrollment and disenrollment of Medicare beneficiaries in the HMOs and (2) the administration of the lock-in features of the HMO projects. Therefore, GAO agreed with Representative Smith's office to provide an interim report addressing these issues.

GAO found that most beneficiaries appear to understand the HMO lock-in provisions and the need to obtain prior authorization for nonemergency medical services outside of the HMOs to which they belong. However, the system for coordinating the HMOs' operations with Medicare's administrative structure, particularly during beneficiary enrollment periods, is vulnerable to duplicate or other erroneous payments to the HMOs, hospitals, physicians, or beneficiaries.

NUMBER OF BENEFICIARIES RECEIVING OUT-OF-PLAN SERVICES

GAO determined that 6,737 Medicare beneficiaries, or 6.4 percent of the 105,000 beneficiaries it compared with the payment files of the regular Medicare program, had potentially received some out-of-plan physicians' services while they were members of the four HMOs. The total potential out-of-plan charges were about $2.6 million. In accordance with the lock-in provision, Medicare should deny (not pay) these claims. Based on all the claims that were denied, about half the beneficiaries had obtained out-of-plan services of $100 or less, and about 9 percent had obtained out-of-plan services of over $1,000.

Sixty-four people had obtained potential out-of-plan services of over $5,000. GAO's analysis of the denied claims of these beneficiaries showed that the beneficiaries had paid about 14 percent and the HMOs paid about 53 percent because (1) the services had been authorized by them and the doctors had sent the claim to Medicare by mistake or (2) when the HMOs learned of the circumstances of the denials, they decided to pay the claims. The doctors had not been paid for 22 percent, and status of the remaining 11 percent was not known. (See p. 12.)

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR PHYSICIANS' SERVICES

Of the $2.6 million in billed charges for out-of-plan physicians' services at the four HMOs, the regular Medicare program correctly denied $1.9 million and incorrectly processed for payment $700,000, or about 29 percent. The $700,000 represents "duplicate" payments because the costs of the services were included in the payment rates to the HMOs. (See p. 10.)

Also, GAO's analysis of the claims for the 64 beneficiaries showed that there was a coordination problem involving the HMOs and regular Medicare in handling denied claims. The Medicare paying agent is supposed to transfer such denied claims to the HMOs so that the HMOs can review and consider paying them if they were for authorized services or if the beneficiary was not at fault. However, GAO could locate claims for only 60 percent of the billed charges at the four HMOs. Thus, to the extent the remaining claims were not submitted to the HMO, the HMO could not act on them. (See p. 13.)

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR HOSPITAL SERVICES

GAO's analysis of the hospital bills applicable to the 64 enrollees with denied physician claims of over $5,000 indicated that HHS' internal controls for coordinating the HMOs' hospital-related services with the regular Medicare program were highly vulnerable to error. In about one-fifth of the hospital admissions GAO reviewed, HHS had not advised its paying agent (a Medicare claims paying contractor, in this instance Blue Cross) that the beneficiaries were enrolled in an HMO. As a result, various hospital-related payment errors occurred.

One apparent cause of the incorrect enrollment information was the lag times between the effective dates of enrollment and when the enrollment date was recorded in the HHS information system. To test whether this problem could be widespread among Medicare HMO enrollees in Florida, GAO compared the lag times for the 13 months from January 1984 through January 1985. GAO found that the enrollment information was recorded

from 16 to 37 days after the effective enrollment dates so that all information HHS provided to its paying agents during these lag times was likely to be incorrect. (See p. 18.)

Incorrect enrollment information was one cause for errors. But the complexity of the coordination system involving HHS, the Medicare paying agents, the HMOs, and hospitals made it impractical for GAO to identify the causes of all the errors. The errors, however, have contributed to the following undesirable situations.

--Hospital bills were incorrectly paid, but the related bills for physicians' services were correctly denied, which could cause beneficiary confusion concerning the lock-in provision.

--The costs of hospital services authorized by the HMOs were not correctly charged to them, resulting in program overpayments.

--The cost of hospital services not authorized by the HMOs were charged to them, which resulted in underpayments to the HMOs or Medicare payments for noncovered services.

--HMOs did not pay beneficiaries' Medicare deductible and coinsurance charges for authorized services as provided under the HMOs' benefits. (See p. 21.)

OTHER ENROLLMENT AND DISENROLLMENT PROBLEMS

GAO also identified two other problems associated with the lock-in provisions and the enrollment and disenrollment procedures where individual beneficiaries appeared vulnerable to thousands of dollars of costs for out-of-plan services. These problems relate to situations in which beneficiaries have obtained out-of-plan services during the "waiting periods" before their effective enrollment dates and after they had requested disenrollment. (See p. 25.) Essentially, during such waiting periods it is not always clear who is responsible for paying medical expenses, and in some cases beneficiaries may be liable for the full cost of medical care.

CASE STUDIES

Although GAO believes that the Congress and the beneficiaries need to know about the system's coordination problems, GAO also believes it is important for all parties to understand how these problems in the enrollment and disenrollment process and the administration of the lock-in feature of the HMO demonstration projects have affected individuals. Therefore, GAO has included case studies of 14 beneficiaries to illustrate the five problem areas discussed in the report. (See p. 32.)

CONCLUSIONS

GAO believes that the system for coordinating the HMOs' operations with the administrative structure for paying hospitals and physicians under the regular Medicare program is vulnerable to error. As shown in the case studies, not only are payment errors costly and disruptive to the program and providers, but they can also affect beneficiaries. In view of this and the fact that the HMO program may expand rapidly under the regulations that became effective in February 1985, GAO believes HHS should direct the Health Care Financing Administration (HCFA) to correct the problems leading to the incorrect payments. This would help prevent similar problems from arising as new HMOs enter the program.

GAO believes that individual beneficiaries are most vulnerable to significant costs of out-of-plan services during the waiting period before their enrollment and after their disenrollment. GAO found, however, that the beneficiaries, their families, or others had actually paid a relatively small portion (14 percent) of the charges for such services. Nevertheless, when individuals incur expenses involving thousands of dollars which may not be paid by either the HMO or the regular Medicare program, it could be a traumatic experience. GAO is continuing to assess the magnitude and specific causes of the problems experienced by beneficiaries entering and leaving HMOs. GAO's final report will address any necessary corrective actions.

Tear Sheet

RECOMMENDATIONS

The Secretary of HHS should direct the Administrator of HCFA to act to identify and correct the systemic problems leading to the erroneous physician and hospital payments GAO found. Corrective action should center on overcoming the problems of intermediaries and carriers not knowing when beneficiaries are enrolled in HMOs because of the delays in recording enrollments and problems with the computerized exchange of data among the Medicare paying agents, HMOs, and HCFA.

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GAO did not obtain comments on the report from HHS, the Medicare paying agents, or the individual HMOs discussed. However, the problems identified were discussed with HHS and paying agent officials.

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ABBREVIATIONS

AAPCC	adjusted average per capita costs
AV-MED	AV-MED Inc.
CAC	CAC Health Plans, Inc.
GAO	General Accounting Office
GPPP	Group Practice Prepayment Plan
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IMC	International Medical Center
OMB	Office of Management and Budget
SSA	Social Security Administration
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

CHAPTER 1

INTRODUCTION

The Medicare program, which began on July 1, 1966, was authorized by the Social Security Amendments of 1965, which added title XVIII of the Social Security Act (42 U.S.C. 1395). Medicare pays for much of the health care costs for eligible persons age 65 or older. In 1972, Medicare was extended to provide protection to certain disabled persons and to individuals suffering from kidney (renal) failure. The program is administered by the Health Care Financing Administration (HCFA), a component of the Department of Health and Human Services (HHS).

Medicare provides two forms of protection. Medicare part A--Hospital Insurance for the Aged and Disabled--covers services furnished by institutional providers, primarily hospitals, home health agencies, and after a hospital stay, skilled nursing facilities. Inpatient care is subject to various deductible and coinsurance amounts. Part A is principally financed by taxes on earnings paid by employers, employees, and self-employed persons. During fiscal year 1984, about 30 million people were eligible for part A benefits, and benefit payments were about $41.5 billion.

Medicare part B--Supplementary Medical Insurance for the Aged and Disabled--covers (1) physicians' services, (2) outpatient hospital care, and (3) other medical and health services. This insurance generally covers 80 percent of the reasonable charges for these services subject to an annual $75 deductible. Enrollment in part B is voluntary. Part B is financed by beneficiaries' monthly premium payments and by appropriations from general revenues. During fiscal year 1984, an average of 28.7 million people were enrolled, and part B benefit payments were about $19.5 billion, of which about 25 percent was financed by enrollees' premiums and about 75 percent by appropriations.

HCFA administers Medicare through a network of contractors, such as Blue Cross and Blue Shield, to process Medicare claims and to make payments on behalf of the government. The contractors that pay institutional providers, such as hospitals and nursing homes, are referred to as part A intermediaries; the contractors that pay for the services of noninstitutional providers, such as doctors, laboratories, and suppliers, are called part B carriers.

HMOS AND MEDICARE

Section 1833 of the original Medicare law included provisions for reimbursing, on a reasonable charge or reasonable cost

basis, group practice prepayment plans (GPPPs) for part B services provided to Medicare eligibles enrolled in such plans. According to HCFA statistics, in June 1984 44 GPPPs were participating in Medicare with about 575,000 Medicare-eligible members. Medicare pays for services received by GPPP members from providers and practitioners who are not affiliated with the GPPP.

The Social Security Amendments of 1972 (Public Law 92-603) added to the law section 1876, which sets forth the conditions under which health maintenance organizations (HMOs) could contract with Medicare. Essentially, section 1876 gave HMOs the option to enter into cost-based or risk-based contracts. Under cost-based contracts, HMOs function similarly to GPPPs except that payments may include the costs of both part A and part B covered services. Also, like the GPPPs, Medicare members can use and receive reimbursement for out-of-plan services.

Section 1876 risk-contract HMOs are also paid on the basis of their costs of providing parts A and B services. However, the HMO's allowed costs per member are compared to the "adjusted average per capita cost" (AAPCC) for all Medicare beneficiaries in the HMO's service area, and if the HMO costs are higher than the AAPCC, the HMO must absorb the loss or carry it over to be offset with future "savings." If the HMO's costs are less than the AAPCC, it shares the savings with Medicare on a 50-50 basis. The HMO's share, however, is limited to 10 percent of the AAPCC. Under risk-type contracts, Medicare enrollees are subject to the "lock-in" feature, which generally provides that except for "emergency and urgently needed services," all health care for enrolled beneficiaries must be provided by or authorized by the HMOs.

Section 114 of the Tax Equity and Fiscal Responsibility Act (TEFRA) (Public Law 97-248) amended section 1876 of the Social Security Act to encourage more risk-based contracts by providing for fixed per patient payment rates of 95 percent of the AAPCC. Instead of sharing any savings with Medicare, section 1876 provides that the savings must be used to provide Medicare members with additional health benefits or reduced cost sharing.[1] The Congress was concerned that the adjustments being made under the methodology used at that time to compute the AAPCC did not adequately reflect the relative health care needs (i.e., disability status and other characteristics) of Medicare beneficiaries who

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[1]Under the four Florida HMO demonstration projects discussed throughout this report, the beneficiaries are not liable for any deductibles or coinsurance amounts as they would be under the regular Medicare program.

enroll in the HMOs as compared to beneficiaries in the regular Medicare fee-for-service system. Thus, payment rates would either be too high or too low depending on whether HMOs attracted relatively more or less healthy beneficiaries. Therefore, the effective date of implementing the HMO amendments made by TEFRA was established as the latter of (1) October 1, 1983, or (2) when the Secretary of HHS notified the cognizant congressional committees that she is "reasonably certain" that an appropriate methodology for computing the AAPCC to assure actuarial equivalence of HMO and non-HMO members had been developed. In May 1984, the proposed regulations to implement section 114 of TEFRA were published. In January 1985, the final regulations were issued to be effective February 1, 1985. The Secretary provided the required notification to the congressional committees on January 7, 1985.

The demonstration projects

In 1982 and 1983, HCFA awarded contracts under its demonstration authority to 26 organizations to develop Medicare competitive health care systems or HMOs. Such demonstration projects became operational in 21 cities across the country. In some cases an organization operated in more than one locality. Like the TEFRA amendment, the per patient payment rates are fixed at 95 percent of the AAPCC. As of October 1, 1984, there were about 219,000 Medicare enrollees in the operational demonstration projects nationwide. In contrast to the operational demonstration projects, 63 HMOs with about 130,000 Medicare members had section 1876 contracts as of June 1984. Of these, 62 had cost contracts and 1 was under a risk contract.

This report deals with four HMO demonstration projects that started in the Miami, Florida, area. These projects had about 112,000 Medicare enrollees on October 1, 1984. The four HMO demonstration projects, the dates they began, their total Medicare enrollment as of December 1, 1984, and Medicare payments to the HMOs as of December 1, 1984, are shown in the following table.

HMO	Inception of projects	Number of Medicare enrollees (Dec. 1, 1984)	Medicare payments through Dec. 1, 1984
			(000 omitted)
International Medical Centers, Inc.	8/1/82	104,090	$273,512
AV-MED Inc.	11/1/82	10,254	26,816
CAC Health Plans, Inc.	10/1/82	4,894	21,429
Health Care of Broward	2/1/83	2,636	9,633
Total		121,874	$331,390[a]

[a]Includes $43,857,000 withheld by HCFA to pay, on the HMOs' behalf, hospital bills for International Medical Centers, AV-MED, and Health Care of Broward.

Source: HCFA.

OBJECTIVES, SCOPE, AND METHODOLOGY

On January 30, 1984, Representative Lawrence J. Smith requested that we review the operations of the four HCFA HMO demonstration projects in south Florida. This request was in response to beneficiary inquiries and complaints received by his office. Later other members of the Florida congressional delegation also asked us to review these HMOs.

As our work progressed, we learned that most beneficiary complaints and concerns identified during our review of HCFA files as well as from inquiries received from the Congressman's office and from other members of the Florida delegation related to (1) the timely recording of beneficiaries' enrollment in and disenrollment from the HMOs (which we call transitioning); (2) the administration of the "lock-in" feature of the HMO projects, which provides that payment will not be made by the HMO or by the regular Medicare program for services provided by institutions or practitioners not affiliated with the HMO unless such services are "emergency services" or "urgently needed services" outside the HMO's service area; and (3) the extent of

beneficiary liability for services provided outside the HMO whether provided on an "emergency" or other basis.[2]

Because of these concerns, we agreed with Representative Smith's office to provide an interim report to primarily focus on the above problems. More detailed information on those problems and other questions to be addressed in the final report will include:

--HMOs' methods of marketing and enrollment.

--Actions being taken to assure that quality care is provided.

--HMOs' contracting arrangements with health care providers, such as hospitals and medical specialists.

--The reasonableness of Medicare HMO payment rates.

Our principal objectives in this phase of our work were to determine

--the number of Medicare beneficiaries who had received out-of-plan services during the period they were enrolled in the HMOs;

--the value of such services expressed in terms of billed charges or, in the case of paid hospital bills, the reimbursed amount;

--whether such charges were denied or correctly/incorrectly paid by the Medicare paying agents (intermediaries and carriers); and

--whether the HMOs assumed financial responsibility for out-of-plan services provided to their members, the beneficiaries or their families were required to pay for such services, or the providers of service had absorbed the revenue losses.

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[2]According to unofficial HCFA statistics, of the 629 complaints involving the four HMOs that were received from various sources from May 1, 1983, through June 30, 1984, about 92 percent pertained to enrollment and disenrollment practices, and 4 percent involved the nonpayment of medical bills and the failure to explain the HMO "lock-in" feature. The other 4 percent appeared to primarily involve quality of care issues.

Another objective was to determine whether the procedures for recording enrollments and disenrollments on HCFA's records contributed to beneficiaries obtaining out-of-plan services or to the Medicare paying agents making incorrect payments.

The HMOs provided us computer tapes identifying each Medicare beneficiary who had enrolled from the project's initiation date through February 29, 1984, and the time periods that these individuals were enrolled. We then matched these individuals and related enrollment data to the payment history records of the principal Medicare carrier in Florida responsible for paying doctor bills (Florida Blue Shield) to determine how many claims it had received for these beneficiaries while they were HMO members and whether the claims had been paid or denied. We eliminated those denials that were identified as "duplicates"--that is, denied more than once--on the payment history tapes. The carrier's payment history tapes included data on the "place of service," including inpatient and outpatient hospital data; we used this information to identify individuals who should have had related hospital bills. For those individuals, we asked the principal intermediary in Florida responsible for paying hospital bills (Florida Blue Cross) for comparable payment and denial information.

From the computer matches for Florida Blue Shield, we arrayed the denied charges by individual to determine the amount of services each had received that were potentially out-of-plan. For those 64 enrollees that the initial computer analysis showed had more than $5,000 of denied doctors' claims, including claims denied more than once, we asked about each case at the applicable HMO and asked selected non-HMO providers who had furnished out-of-plan services what had occurred.

For these 64 enrollees, we analyzed Florida Blue Cross records to identify any payments made by it to hospitals while the individuals were enrolled in the HMOs. We determined whether

HCFA's query process[3] had correctly identified the individuals as HMO members and advised the intermediary and hospitals accordingly. We also wanted to determine when Blue Cross paid hospital bills on behalf of an HMO, whether such payments were shown on the HCFA bill itemization lists for deductions from the HMOs' capitation payments. There is no comparable provision for Blue Shield to pay doctors' bills on behalf of the HMOs.

As requested by Representative Smith, we did not obtain comments from HHS or the HMOs on this report. Except as noted above, our work was done in accordance with generally accepted government audit standards.

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[3]An internal control mechanism to advise the paying agents that patients are eligible for Medicare and that they have not exhausted their benefits. According to HCFA instructions, a hospital that provides hospital inpatient services to a Medicare beneficiary sends an admission notice to the intermediary (e.g., Florida Blue Cross) for all admissions, including those for HMO members. Blue Cross then queries HCFA to determine (1) the status of the beneficiary (HMO member or not) and certain other information from HCFA's Health Insurance Master File and (2) the payment option that the particular HMO had elected to use. Three of the four Florida HMOs (IMC, AV-MED, and Broward) had elected the payment option under which the intermediary processes and pays the bills on behalf of the HMOs, except for those hospitals that had agreements with the HMO for it to pay bills directly. CAC had elected the payment option to process and pay all hospital bills on behalf of its members.

For bills received by the intermediary for part B outpatient hospital services, the intermediary may query HCFA to determine the HMO status of the beneficiary and the payment option selected by the HMO, depending on whether the intermediary knew that a beneficiary's part B deductible had been satisfied. There is a similar HCFA query system for carriers under part B which is also used depending on the status of the part B deductible. Also, HCFA provides its contractors an automatic notice of changes in beneficiary status so that the paying agents can update their records to identify HMO members.

CHAPTER 2

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR PHYSICIANS' SERVICES

Overall, 6,737 Medicare beneficiaries, or 6.4 percent of the 105,000 beneficiaries we screened, had potentially received some out-of-plan part B services while they were members of one of the four HMOs.[1] This included 1,530 beneficiaries where Florida Blue Shield had paid all of the claims for out-of-plan services. Of the remaining 5,207 beneficiaries with denied claims, about 9 percent of them had denied claims exceeding $1,000, and they accounted for about 66 percent of the total gross denied charges. This indicates that the problems of out-of-plan services that result in large beneficiary liabilities involved relatively few individuals.

Based on submitted charges (that is, the amounts the doctors charged), the net value of the out-of-plan part B services was about $2.6 million, of which Florida Blue Shield (or its predecessor in south Florida) correctly denied about $1.9 million and incorrectly paid claims with submitted charges of $700,000, or about 29 percent. The amounts Blue Shield paid represent "duplicate" payments because these services were included in the HMOs' capitation or premium amounts.

In addition to the relatively high incidence of incorrect payments for out-of-plan services, we believe that there is also a coordination problem involving Florida Blue Shield and the HMOs in handling claims denied by the Medicare carrier. This problem has contributed to situations where a provider or beneficiary was not paid by the HMOs because the HMOs were not advised of the outstanding claims.

HOW PAYMENTS FOR HMO MEDICARE ENROLLEES SHOULD BE MADE

Medicare's capitation payments to HMOs are supposed to be payment for all covered services needed by enrolled beneficiaries. Therefore, once a beneficiary is enrolled in an HMO, Medicare should make no payments on his/her behalf except for the capitation payment. When the beneficiary enrolls in an HMO, he/she agrees to receive services only from providers affiliated

[1]We use the term "potentially" because during our review of individual cases, we found that the Medicare carrier had received claims for services that had been authorized by the HMOs and should have been submitted to the HMOs.

with the HMO, and if the beneficiary goes to a non-HMO provider, neither the HMO nor Medicare is obligated to pay and the beneficiary is personally liable. The only exceptions to this rule are

--when the HMO authorizes the beneficiary to go to a non-HMO provider for services,

--when the beneficiary requires emergency services, or

--when the beneficiary is not within the HMO's service area (for example, while traveling) and requires services urgently.

In these cases the HMO, but not Medicare, is liable for payment.

If a beneficiary goes to a non-HMO provider for an unauthorized, nonemergency service, he/she is personally liable for full payment. If Medicare were to pay for such a service, it would be making duplicate payments because it has already paid the HMO, through the capitation payment, for the service. In effect, unauthorized, nonemergency services for HMO enrollees from providers, other than the HMO itself, are noncovered services under Medicare.

NUMBER OF HMO MEDICARE ENROLLEES WITH OUT-OF-PLAN SERVICES

As summarized in the following table, our computer match of HMO enrollees with Florida Blue Shield part B payments showed that over 6 percent of the Medicare enrollees at the four HMOs potentially had received some out-of-plan part B services.

HMO	Period	HMO Medicare enrollees screened	Those potentially receiving out-of-plan services	
			Number	Percent of enrollees screened
IMC	8/1/82 - 2/28/84	86,257	5,321	6.2
AV-MED	11/1/82 - 2/28/84	10,547	973	9.2
CAC	10/1/82 - 2/28/84	5,176	337	6.5
Broward	2/1/83 - 2/28/84	3,087	106	3.4
Total		105,067	6,737	6.4

The data in the above table may understate the number of Medicare beneficiaries enrolled in the four HMOs who potentially received out-of-plan services. Our computer match would not identify beneficiaries who obtained out-of-plan services but did not submit a claim for them to Florida Blue Shield or who received out-of-plan services in geographic areas where the claim would have been submitted to another carrier.

Of the 6,737 HMO enrollees potentially receiving part B out-of-plan services, we identified 1,595 who had also received inpatient or outpatient hospital services.

AMOUNTS OF POTENTIAL OUT-OF-PLAN PHYSICIANS' SERVICES INCLUDE TOO MANY PAID CLAIMS

The value of part B services that were potentially out-of-plan for the 6,737 HMO Medicare enrollees expressed in terms of billed charges for the denied claims and billed and allowed charges for the paid claims is summarized in the following table.

	Number of line items[a]	Amounts Billed	Amounts Allowed
Claims denied	37,122	$2,149,700	b
Less apparent duplicate denials	5,428	294,115	b
Adjusted total	31,694	1,855,585	b
Claims allowed	12,441	745,097	$562,234
Total	44,135	$2,600,682	

[a]A line item represents a specific type of service, such as an office or hospital visit each time it is claimed.

[b]Not applicable.

Of the $562,234 in allowed charges for the claims paid, Blue Shield paid about 80 percent, and the beneficiary was liable for the remaining 20-percent coinsurance and any unpaid deductible. The amounts Blue Shield paid represent "duplicate" payments because these services were included in the HMOs' capitation or premium amounts and these payments were therefore incorrect.

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Compared with the total value ($2,600,682) of the part B out-of-plan services identified in our computer match, the incorrect billed amounts ($745,097) represent about 29 percent. We believe this "error" rate is too high.

We asked Florida Blue Shield for explanations of how these incorrect payments occurred for 25 beneficiaries who had allowed charges of about $30,500. The carrier told us that the erroneous payments for 9 of the 25 beneficiaries resulted because before December 1983 its claims processing system did not maintain for beneficiaries who disenrolled from an HMO a record of the beneficiaries' enrollment periods. Thus, if a claim for an out-of-plan service provided when the beneficiary was an HMO enrollee was submitted after disenrollment, the computer would not identify the claim as noncovered and it would be paid. For the other 16 beneficiaries, Florida Blue Shield said that the problem apparently lies with delays by HCFA in notifying the carrier that the beneficiary had enrolled in an HMO. The carrier said that weeks or months passed before it was notified of enrollment in an HMO. If an out-of-plan claim was submitted in the interim, the carrier would pay it because it did not know it was for a noncovered service.[2]

The beneficiary case studies in appendix II include five examples that illustrate these problems.[3] In four of the cases, Blue Shield told us that the incorrect payments were due to the problem with its computer system, and in the other case, Blue Shield told us the problem was due to the untimely updating of records by HCFA. In two of the five case studies, both Blue Shield and the HMO had paid the same doctors for the same services.

DISTRIBUTION OF AMOUNTS OF POTENTIAL OUT-OF-PLAN SERVICES

We arrayed the denied part B claims by beneficiary to develop a distribution by the amount of the denials. As shown by the following table, about half the beneficiaries had out-of-plan denied claims amounting to $100 or less which represented nearly 6 percent of the total value of potential out-of-plan services. In contrast, about 9 percent of the beneficiaries

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[2]At Blue Shield's request, we provided a listing of the claims involved with the $562,234 in erroneously allowed charges we identified in order for the carrier to request refunds from the parties paid in error.

[3]See cases of Ms. B., Ms. C., Mr. W., Mr. R., and Ms. G. in appendix II.

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(492) had denials of more than $1,000. These denials represented about 66 percent of the total value of potential out-of-plan services. This indicates that the problems with the lock-in provision and out-of-plan services which result in significant beneficiary liabilities involve relatively few individuals.

Part B amounts denied	Submitted charges on part B claims denied: Number of beneficiaries	Percent	Total amounts denied	Percent	Submitted charges on part B claims allowed: Number of beneficiaries	Amount
$1 to $100	2,734	52.5	$ 124,590	5.8	624	$143,992
$101 to $500	1,656	31.8	376,841	17.5	409	158,706
$501 to $1,000	335	6.4	234,731	10.9	111	59,353
$1,001 to $5,000	418	8.0	890,985	41.4	153	107,507
Over $5,000	64	1.3	522,553	24.4	24	37,691
Subtotal	5,207	100.0	2,149,700	100.0	1,320	507,249
All out-of-plan claims paid	1,530		a		1,530	237,848
Total	6,737		$2,149,700		2,850	$745,097

[a]Not applicable.

Of the 6,737 beneficiaries with out-of-plan services, 1,320 beneficiaries had some claims denied while others were allowed and paid. In our view, this inconsistency could be confusing to beneficiaries and would not facilitate beneficiary understanding of the HMOs' lock-in provisions. According to the enrollment forms, beneficiaries are told that if they obtain services out-of-plan, other than emergency or urgently needed services, neither the HMOs nor Medicare will pay. However, if Medicare does pay in some of these instances, the beneficiaries are getting mixed signals.

BENEFICIARIES WITH MORE THAN $5,000 DENIED PART B CLAIMS

The 64 beneficiaries that the computer match showed as having total denied part B claims of over $5,000 each (including multiple denials of claims for the same service) while they were enrolled in an HMO were distributed among the four HMOs as follows.

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HMO	Number of beneficiaries	Part B billed charges: Amounts denied	Part B billed charges: Amounts allowed
IMC	42	$338,902	$13,543
AV-MED	11	84,754	7,621
CAC	9	82,962	16,527
Broward	2	15,935	-
Total	64	$522,553	$37,691

We found that overall, the 64 Medicare beneficiaries, their families, or others had paid a relatively small portion (about 14 percent) of the billed charges on the unduplicated denied claims. The HMOs had paid, settled, or were reviewing about 53 percent of the charges denied by Blue Shield. Reasons why the HMO paid or settled the claims were (1) the services had been authorized by the HMO and the provider had sent the claims to Blue Shield in error and (2) when the HMOs learned of the denials and the circumstances of the out-of-plan services, they decided to accept financial responsibility for them. The providers had not been paid for 22 percent of the total denied charges. The status of the remaining 11 percent of the denied charges either is unknown or will probably be paid by the regular Medicare program because the beneficiary was "retroactively" disenrolled to his/her initial enrollment date.

A summary of the disposition of the denied claims for the 64 beneficiaries for each of the four HMOs is included in appendix I.

NEED FOR BETTER EXCHANGE OF INFORMATION ON DENIED CLAIMS

According to HCFA instructions, when Florida Blue Shield denies a claim because it involves an HMO member, it should transfer the claim to the HMO. We believe that compliance with this instruction is important for two reasons. First, the HMO may have authorized the services or the services may have been provided under circumstances where the beneficiary was without fault and the HMO might settle the claim it received. Second, if the HMOs do not receive the denied claims, they have difficulty identifying enrollees who are getting services out-of-plan and providing these individuals with appropriate education and guidance on the lock-in provision.

For the 64 beneficiaries with denied claims of over $5,000, we were not able to locate the claims for about 40 percent of the billed charges at the four HMOs we visited. This means that

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either Blue Shield had not transferred the denied claims to the HMO as it was supposed to or the claims were transferred and the HMOs had lost them. Based on the HMOs' correspondence controls, we believe that the former was the case.

Eight of the case studies in appendix II illustrate this problem.[4] In seven of the eight cases we believe that there was an adverse effect on beneficiaries or providers because the HMOs probably would have paid the claims if they had received them. In these cases, either (1) the claims were in connection with hospital admissions that the HMOs had authorized and they had paid other related doctors' bills or (2) the beneficiaries were not at fault. In one case (Mr. F.) a beneficiary was in the hospital on the effective date of his enrollment and he or his wife had paid $5,757 in doctors' bills denied by Blue Shield for related physicians' services provided after the effective date. We could not locate Mr. F.'s denied claims at the HMO. The remaining case study (Ms. Z.) involves a situation where the HMO had denied all the Blue Shield-denied claims for this beneficiary that we located at the HMO.

CONCLUSION

A large majority of the beneficiaries enrolled in the four Florida demonstration projects appeared to have understood the lock-in provision. Only about 6 percent of the beneficiaries compared against the Blue Shield claims history files had obtained some out-of-plan part B services while they were enrolled. In terms of denied claims for out-of-plan services, the distribution is highly skewed in that of 5,207 beneficiaries with submitted charges on part B claims denied, 482 accounted for nearly 66 percent of the total denied charges. Blue Shield had incorrectly paid about 80 percent of the $562,234 in allowed charges for the claims paid. We believe that there is a need for better coordination between the Medicare part B carrier and the HMOs in handling denied claims.

In summary, we believe that the system for coordinating the HMOs' operations with the administrative structure for paying for physicians' services under the regular Medicare program is vulnerable to error. In view of the fact that HMO programs to serve Medicare beneficiaries may expand rapidly under the January 1985 regulations implementing section 114 of TEFRA, we believe that HCFA should correct the problems leading to the incorrect payments discussed in this chapter. This would help prevent similar problems from arising elsewhere when additional HMOs join the program. The recommendation we make in chapter 3 would also address the payment problems discussed in this chapter.

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[4]See cases of Mr. C. S., Mr. F., Ms. R., Ms. Z., Mr. W., Ms. G, Mr. M., and Ms. T. in appendix II.

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CHAPTER 3

COORDINATION PROBLEMS INVOLVING PAYMENTS FOR HOSPITAL SERVICES

Our analysis of the hospital bills applicable to the 64 enrollees with denied part B claims over $5,000 showed that there were a series of coordination problems involving three of the four HMOs, hospitals, Florida Blue Cross, and HCFA regarding inpatient and outpatient hospital services provided to HMO members. A lack of communication or erroneous communications among them were resulting in erroneous payment of claims and delays in making payments. The coordination problems have contributed to the following undesirable situations:

--Hospital bills were erroneously paid by the intermediary, whereas the related inpatient claims for physicians (part B) services were correctly denied by the carrier. This could cause beneficiary confusion concerning the lock-in provision.

--The cost of hospital services that were authorized by the HMOs were not correctly charged to them, which would result in Medicare overpayments to the HMOs.

--The cost of services not authorized by HMOs were charged to them without a determination that they were "emergency" services, which would result in underpayments to the HMOs.

--HMOs did not pay beneficiaries' deductible and coinsurance charges for authorized services as they were supposed to do, principally because Blue Cross had not notified the HMOs of the payments made on their behalf.

--Hospitals could be misled or confused because the intermediary had not advised them that patients were enrolled in an HMO.

Although the beneficiary cases that we studied were not typical because of their high use of health services, we believe that the coordination problems identified are systemic and, thus, could occur for other HMO members using hospital services. This is especially true shortly after their enrollment, when it is important that all parties know a beneficiary is in an HMO so claims can be properly processed.

To test this hypothesis, we analyzed the time lags between the effective dates of enrollment for all HMO members in south

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Florida and the dates the information was recorded in the HCFA file used to respond to hospital admission notices. This analysis showed that for the 13 months from January 1984 through January 1985, the information was recorded from 16 to 37 days after the effective enrollment dates. (See p. 18.) Therefore, any hospital admission notices submitted to HCFA during these lag times would be likely to result in incorrect responses to the hospital regarding eligibility for services.

HOW THE HOSPITAL ADMISSION NOTICE PROCESS SHOULD WORK

When a Medicare beneficiary is admitted to a hospital, the hospital notifies its intermediary, which in turn asks HCFA for information on the beneficiary's eligibility for services. HCFA responds as to whether the individual is covered by Medicare, whether the inpatient deductible applies to the beneficiary, and how many days of coverage are available. This response enables the hospital to correctly charge the patient for the amount he/she is personally liable for.

If the beneficiary is enrolled in an HMO, the response to the hospital admission notice so indicates. The hospital then knows it has to seek payment from the HMO[1] and can assure that appropriate authorization is obtained from it. Thus, the accuracy of HCFA's response is important to assure correct payment for the hospital stay.

ANALYSIS OF HOSPITAL BILLS PROCESSED BY BLUE CROSS FOR MEMBERS OF IMC, AV-MED, AND BROWARD

Of the 64 beneficiaries with denied part B claims over $5,000, 55 were members of IMC, AV-MED, and Broward. These HMOs had elected to authorize the fiscal intermediaries[2] in Florida to make payments on their behalf to institutional providers, such as hospitals, that did not have a direct agreement with the HMOs. Our analysis of the "place of service" shown on part B claims indicated that all of these beneficiaries had received hospital services while they were enrolled. We identified

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[1]In some instances, Medicare will pay the hospital on behalf of the HMO and deduct the hospital payment from future payments to the HMO. In such cases the intermediary is responsible for determining if the HMO has authorized the care and notifying the hospital.

[2]There are four intermediaries serving providers in Florida. Florida Blue Cross is the principal one.

inpatient and/or outpatient hospital bills for 46 of the 55 beneficiaries that had been processed by Blue Cross for services provided while they were members of the three HMOs.

A discussion of our findings in relation to adherence with the HCFA procedures and instructions follows.

Inpatient hospital services

According to HCFA instructions, depending on HCFA's response to the hospital admission notice, the intermediaries, the HMOs, and the hospitals are supposed to do various things regarding the bills. For example, if the response shows that the beneficiary is an HMO enrollee, the intermediary should determine whether the hospital has an agreement with the HMO, in which case the hospital is instructed to send the bill to the HMO. If the hospital does not have an agreement with the HMO, the hospital is instructed to send the bill to the intermediary, and the intermediary is responsible for determining whether the admission was authorized by the HMO. If the admission was not authorized (out-of-plan), the hospital should send documentation to the intermediary on the emergency nature of the services within 3 days of the notice to the hospital so the intermediary can make a determination whether to pay the bill.

Further, the instructions provide that when the intermediary processes a bill on behalf of an HMO, it should send an information copy to the HMO. Under the Florida demonstrations, this information provides one basis for the HMO to pay any deductible and coinsurance charges on behalf of the member as is provided under their benefit structures.

If the response does not show that a beneficiary is an HMO member, the hospital is advised accordingly, and the bill should be processed as a regular Medicare claim.

When Florida Blue Cross pays a bill on behalf of an HMO (either as an authorized admission or as an "emergency"), the payment is supposed to be deducted from the HMO's capitation payments.[3] One procedure for accomplishing this is that Blue Cross submits a monthly record of all its payments to HCFA. HCFA edits the records to determine whether the beneficiary was enrolled in an HMO when the services were provided. If so, the payment is listed on a bill itemization list for each HMO which HCFA uses to calculate the deductions. One problem with this

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[3]This deduction is necessary because in computing the capitation payments to the HMOs, the average cost of Medicare hospital benefits in the geographical area has been included.

procedure is that the payment information furnished by Florida Blue Cross does not show whether the bill was paid on behalf of the HMO (either as an authorized admission or an emergency), and this can result in the cost of services not authorized by the HMO being charged to it. According to HCFA officials, HCFA relies on the HMOs to identify these situations through their review of the bill itemization lists.

In 10 of the 55 members' admissions we reviewed, when Blue Cross notified HCFA of the admission, it was not correctly advised that the beneficiary was an HMO member. In 2 of the 10 cases, the incorrect HCFA response did not result in any incorrect or inconsistent payments because the bills were rejected by Blue Cross and the admission had not been authorized by the HMO.

We believe that one cause of the problems associated with the incorrect HCFA responses was delays in recording in the HCFA Health Insurance Master File the beneficiaries' enrollment in the HMO. In all 10 cases where HCFA had supplied the intermediary with incorrect information, the admission occurred during the first month of enrollment.

To determine whether the problem of incorrect responses during the first month of enrollment would be unique to the beneficiaries we studied, we analyzed for the period January 1984 through January 1985 the time lags between the effective dates of enrollment for all Medicare HMO enrollees in south Florida and the dates the information was posted to HCFA's Health Insurance Master File.

As shown in the following table, the time lag ranged from 16 to 37 days. To the extent that HCFA received inquiries during these lag periods, HCFA would have provided incorrect responses.

Effective date	Number enrolled	Dates posted	Time lag (days)
January 1, 1984	18,086	February 4, 1984	35
February 1, 1984	22,456	February 25, 1984	25
March 1, 1984	11,888	March 16, 1984	16
April 1, 1984	9,226	April 28, 1984	28
May 1, 1984	7,986	May 16, 1984	16
June 1, 1984	9,952	July 7, 1984	37
July 1, 1984	8,098	July 25, 1984	25
August 1, 1984	6,229	August 23, 1984	23
September 1, 1984	6,925	September 27, 1984	27
October 1, 1984	7,790	November 1, 1984	32
November 1, 1984	8,023	November 24, 1984	24
December 1, 1984	7,812	December 28, 1984	28
January 1, 1985	7,126	January 18, 1985	18

Of the 55 members' admissions we reviewed, Blue Cross made payments for 44. The HMOs had a record of 22 of these payments. For the remaining 22 admissions, the related deductible and coinsurance amounts that the HMOs had not paid totaled about $7,400. We did not determine whether these underpayments were absorbed by the beneficiaries or the hospitals.

Of the 44 admissions for which payment was made, 40 were authorized by the HMO and 4 were not. We located the payments for 31 admissions on HCFA's bill itemization lists to be deducted from the HMO's payments. However, we could not find on the lists the payments for 13 admissions totaling about $74,700. Whether the admissions were authorized by the HMO or not, these payments represent potential program overpayments. If they were authorized and not deducted from the HMO's capitation payments, they represent duplicate payments. If they were not authorized, they represent payments for noncovered services. We have provided HCFA officials with a list of the payments we could not locate to see whether they could find them.

Overall, of the 44 admissions for which payments were made by Blue Cross, 17 totaling about $94,707 were correctly and consistently handled in accordance with HCFA procedures. For these 17 admissions, (1) HCFA's notification correctly showed that the beneficiaries were members of an HMO, (2) the HMO had authorized the admission, (3) the HMO had a record of the payment by Florida Blue Cross, and (4) the payment was listed on the HCFA bill itemization lists to be deducted from the HMO's capitation payments. The other 27 admissions involving payments of about $186,634 were not handled correctly in all respects. Because of the complexity of the coordination system involving HCFA, the intermediary, the HMOs, and the hospitals, it was not practical for us to identify the causes of all the errors. Our analysis of the Blue Cross payments involved in the 44 admissions is shown on the following table.

Description	Potential adverse effects[a]	Number of admissions	Amounts paid
Admissions correctly handled by HCFA, Blue Cross, and HMOs in all respects	None	17	$ 94,707
Admissions not correctly and consistently handled, HCFA response incorrect:			
Services authorized and charged to HMO with HMO having record of payment	None	1	$ 7,250
Services not authorized and not charged to HMO	1. No review to determine "emergency"		
	2. Medicare overpayment	1	12,118
Services authorized and charged to HMO, but HMO had no record of payment	HMO would not pay beneficiaries' deductible and coinsurance	4	21,699
Services not authorized but charged to HMO and related part B claims denied	1. No review to determine emergency 2. Medicare payment for noncovered services 3. Underpayment to HMO 4. Beneficiary confusion concerning "lock-in"	2	7,543
Subtotal		8	48,610
HCFA query response correct but:			
Services authorized and charged to HMO, but HMO had no record of payment	HMO would not pay any beneficiaries' deductible and coinsurance	7	75,484
Services authorized and not charged to HMO	Medicare overpayment	11	52,352
Services not authorized and not charged to HMO	Medicare overpayment	1	10,188
Subtotal		19	138,024
Subtotal not correctly or consistently handled		27	186,634
Total payments		44	$281,341

[a]In some cases where services were authorized but not charged to the HMO, the HMO also had no record of payment so that an additional adverse effect would be that the HMO would not pay the beneficiaries' cost sharing charges for covered services as provided for in its plan. Also to the extent that hospitals were not advised that a beneficiary was a member of an HMO due to the incorrect HCFA response to the admission notice, they could have been misled or confused.

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Five of the case studies involving six admissions included in appendix II illustrate the coordination problems with the Medicare intermediary and the HCFA response to the admission notice process. For five of the six admissions, the HCFA response was incorrect and the case studies show the wide variety in the types and adverse effects of the payment errors that occurred. For example, a hospital was incorrectly paid for services not authorized by the HMO, but the costs of the services were charged to the HMO's capitation payments (Mr. V.). In another case, the admissions were authorized by the HMO but not charged to the HMO for deduction from its capitation payments (Mr. M.). In another case, the beneficiary's cost sharing amounts were not paid by the HMO (Ms. R.). In another case, the hospital was incorrectly paid for an admission not authorized by the HMO and the cost was not charged to the HMO (Mr. T. S.), and in the other case the cost was not charged to the HMO (Ms. C.).

Outpatient hospital services

Outpatient hospital services are Medicare part B benefits which are usually paid by intermediaries (Blue Cross) and the requirements for asking HCFA about beneficiary eligibility vary depending on whether a beneficiary has met the annual $75 part B deductible. (See p. 1.) However, except for "emergency" or urgently needed medical services, when Blue Cross makes a payment for such services on behalf of an HMO enrollee, the services should be authorized by the HMO. Blue Cross should notify the HMO of the payment, and if the services were authorized, the HMO should pay the beneficiaries' cost sharing charges. Also, the amounts paid by Blue Cross should be charged against the HMO's capitation payments.

We identified 26 bills for outpatient hospital services paid by Blue Cross (or applied to the part B deductible) for 12 of the 55 IMC, AV-MED, and Broward beneficiaries reviewed in detail. The Blue Cross payments totaled about $5,900, excluding the beneficiaries' cost sharing charges. Six of the payments were consistently processed in all respects in that (1) the services were authorized by the HMOs, (2) the HMOs paid the beneficiaries' cost sharing charges, and (3) the payments were located on the HCFA bill itemization lists to be charged against the HMO capitation payments.

Two paid bills for services not authorized by the HMO were not located on the HCFA bill itemization lists, so those represented payments for noncovered services. For two bills the services were authorized, but the HMO had not paid the beneficiaries' cost sharing amounts as it should have. For the other 16 outpatient hospital bills, the payments were not consistently

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handled. Although the payments were shown on HCFA's bill itemization list to be charged to the HMOs, the HMOs' records did not show that the services were authorized, nor did the HMOs have a record of the Blue Cross payments or pay the enrollees' cost sharing amounts, which totaled about $1,500.

For 2 of the 12 beneficiaries, Blue Cross had asked HCFA about beneficiary eligibility and had been advised that they were HMO members. For the other 10 beneficiaries, we did not determine whether Blue Cross was aware they were HMO enrollees at the time the payments were made. In any event there is a coordination problem because if the Blue Cross payments were covered services, the HMOs should have paid the beneficiaries' cost sharing charges. However, if the payments were for non-covered (out-of-plan) services, they should not be charged against the HMOs' capitation payments, but depending on who was at fault, should be recovered from the hospitals or beneficiaries.

HCFA AWARENESS OF THE SYSTEMIC PROBLEMS

HCFA has been aware of the systemic problems discussed in this and the previous chapter involving the HCFA beneficiary eligibility response process for some time. For example, a November 1977 memorandum by the staff responsible for HMOs pointed out that intermediaries had not been sending paid bills for HMO enrollees to the HMOs as they had been instructed to do. This situation led to the development of the HCFA bill itemization lists so that HMOs could have another source of information on their enrollees' utilization.

In December 1984, the same HCFA group was developing a procurement request to obtain telecommunications services to support payments to the HMOs. The justification for the proposed procurement stated that:

> "Early in 1982 the Group Health Plan Operations Staff became concerned about the ability of the current HMO accretion/deletion and record keeping system to meet the need of greatly expanded HMO risk contracting activity. In 1982, the number of risk contracts increased [including the HMO demonstration projects] from one to just over 30. Significant additional growth in the number of contracts and a 50% increase in enrollment is predicted for 1985.
>
> "While the processing system had never been adequate, because it had never operated on the schedule designed; this had not been a significant problem when almost all of the HMO contracts were 'cost' contracts.

Only with [a] large increase in 'risk' contracts did the system require immediate improvement."

. . . . .

"For risk contracts it is extremely important to annotate the [Health Insurance Master Record] quickly when a beneficiary joins and to remove the annotation quickly when the beneficiary disenrolls. The annotation prevents improper duplicate payments. The removal of the annotation permits claims to be paid by Medicare contractors without undue delay in payment after disenrollment."

. . . . .

"The current system has never been capable of making changes in the two files on the first day of the month even for routine transactions. For any transaction containing an error the recording of an enrollment or disenrollment typically takes two or three months.

"Under the current system, when HCFA employees need to determine the status of an individual because of complaints or inquiries from beneficiaries, carriers, intermediaries, congressional staff, etc., it takes a minimum of 10 days just to determine the state of an individual's record in the system."

The proposed procurement is designed to provide more timely access by HCFA and HMO personnel to determine the enrollment status of any beneficiary, but it probably will not result in a more timely recording to the Health Insurance Master File.

CONCLUSION

The time lags between the effective dates of enrollment and the recording of such data on the HCFA files used to respond to hospital admission notices make the system for coordinating the HMOs' operations with the administrative structure for paying hospitals under the regular Medicare program vulnerable to error. As shown in the case studies in appendix II and also in chapter 2, not only are payment errors disruptive to the program and providers but they can also adversely affect beneficiaries. Because of this and the imminent expansion of the HMO program, HCFA should act to correct the payment problems discussed in this and the prior chapter.

RECOMMENDATION

The Secretary of HHS should direct the Administrator of HCFA to take action to identify and correct the systemic problems leading to the erroneous physician and hospital payments we found. Corrective action should center on overcoming the problems of intermediaries and carriers not knowing when beneficiaries are enrolled in HMOs because of the delays in recording enrollments and problems with the computerized exchange of data among the carriers, intermediaries, HMOs, and HCFA.

CHAPTER 4

OTHER ENROLLMENT AND DISENROLLMENT PROBLEMS

In addition to the coordination problems involving the HMOs and the administrative structure for paying providers under the regular Medicare program, we identified two other problems associated with the lock-in provisions and the enrollment and disenrollment procedures. The first problem relates to whether and when the HMOs or the regular Medicare program are responsible for the cost of services provided to beneficiaries who are hospitalized during the period from when the beneficiary signs an enrollment form and the effective date of the enrollment and are in the hospital on the effective dates of their enrollment. The second problem relates to beneficiaries who obtain out-of-plan services during the period when they have signed a disenrollment form but must continue to obtain services through the HMO until the effective date of disenrollment.

Solving these problems would involve either a clarification or modification of the law, regulations, and/or related HCFA instructions as contrasted to the basic systemic and internal control problems discussed in the previous chapters.

UNCERTAIN STATUS OF BENEFICIARIES IN THE HOSPITAL ON THE EFFECTIVE DATE OF ENROLLMENT

The enrollment regulations and procedures do not clearly spell out the status of a beneficiary who is hospitalized after he/she signs an enrollment form for an HMO and is in the hospital on the effective date of HMO membership. Under the demonstration projects, this period could range from 2 to 6 weeks. We identified at least seven cases where a beneficiary was in the hospital on the effective date of HMO membership. In at least five of the seven cases, Blue Cross had paid the hospital bill (including the period the beneficiary was enrolled in the HMO) under regular Medicare part A, because the admission and HCFA's response to the inquiry about eligibility status were based on a date before the effective enrollment date. However, in all seven cases most of the related doctor bills for services provided on and after the effective enrollment date were denied by Blue Shield.

Further, because the HMOs did not authorize the hospital admission, their responsibility for these doctor bills was not clear--although our analysis indicated that these seven beneficiaries were without fault. In one case, the HMO routinely paid

for part B services on or after the effective date. In four cases, the HMO had reviewed those claims it received and had paid all or part of them, but in two cases, the HMO had not received any denied claims from Blue Shield and consequently had paid nothing.

Although the incidence of such cases was relatively small, the financial impact on specific individuals and their families was potentially catastrophic. (See cases of Mr. C. S. and Mr. F. in appendix II for examples of individuals hospitalized before their effective enrollment date.)

One solution would be to clearly spell out in the regulations that regular Medicare would be responsible for the portion of the medically necessary hospital and doctor bills up to the effective enrollment date and the HMOs would be responsible for the portion of the bills incurred afterward even though it might not be practical to transfer the medical management of the cases to the HMO. Alternatively, Medicare could be made responsible for all costs until the patient is discharged and the monthly capitation payment proportionately reduced for the days involved.

SERVICES OBTAINED DURING THE DISENROLLMENT WAITING PERIOD

Of the 64 individuals with total denied part B claims over $5,000, at least 14 began to obtain out-of-plan services on the same day or within a week[1] of the date that he/she signed the HMO disenrollment forms. The HMO disenrollment forms included a statement that all services, except "emergency" or "urgently needed" services, had to be provided or arranged by the HMO until the effective date of the disenrollment, which under the demonstrations should have been from 2 to 6 weeks later.[2] Nevertheless, these beneficiaries incurred substantial out-of-plan medical bills for which they were liable during the waiting periods. (See cases of Mr. V., Mr. T. S., and Mr. R. in appendix II.) None of these denied claims were appealed to HCFA under the available formal appeals procedures.

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[1]The normal waiting period was from 2 to 6 weeks. We selected a 1-week period to describe this problem on the assumption that under any modification to the existing HCFA system, it would not be practical to process and record disenrollment more timely than that.

[2]In addition to an indication of the effective date on the disenrollment forms, beneficiaries are later informed by letter from the HMOs of the effective disenrollment dates.

Section 114 of TEFRA and the related January 1985 regulations provide that a member may terminate his/her enrollment with an HMO no earlier than the first day of the second month following the month in which the HMO receives the request for the termination. In other words, under TEFRA if an HMO received the request for disenrollment any time during the month of January, the disenrollment would not be effective until March 1, which would make the waiting period a minimum of about 4 weeks and a maximum of about 8 weeks.

Further, TEFRA provides that enrollees have the right for a hearing (called reconsiderations and appeals) before the government in the case of enrollee dissatisfaction with the failure of the HMO to provide services to which the enrollee believes he/she is entitled, if the amount in controversy is $100 or more. The regulations implementing TEFRA are similar to the previous regulations on beneficiary appeals (42 C.F.R. 405.2056 - 405.2063) for Medicare HMO enrollees, and our review of HCFA reconsideration and appeals files identified no formal appeals to the government involving the four HMO demonstration projects in Florida.

We believe that regular Medicare coverage should be made available for those beneficiaries who obtained necessary services during the waiting period between the date that they apply for disenrollment and the effective date. This could be accomplished by the HMO furnishing the beneficiary with a validated and accepted disenrollment form to accompany any claims to the Medicare paying agents. In our opinion, when a beneficiary is dissatisfied with an HMO service and believes he/she needs medical treatment, the beneficiary should not have to wait several weeks or months to obtain it. On the other hand, if it is eventually shown through complaints and grievances that an HMO was remiss in not providing needed services that a beneficiary obtained out-of-plan shortly after disenrollment, the HMO should be required to accept the responsibility for such services. This would discourage HMOs from withholding treatment as a means of encouraging enrollees with costly health problems to disenroll.[3]

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[3]Although we cannot say such a situation actually occurred, the incentives exist under the TEFRA and demonstration project reimbursement methodology.

CONCLUSION

We believe that individual beneficiaries are most vulnerable to significant costs of out-of-plan services during the waiting period before their enrollment and after their disenrollment. However, as discussed in chapter 2, the beneficiaries, their families, or others had actually paid a relatively small portion (14 percent) of the charges for such services. Nevertheless, we believe that when individuals incur expenses involving thousands of dollars which may not be paid by either the HMO or the regular Medicare program, it could be a traumatic experience. We are continuing to assess the magnitude and specific causes of the problems experienced by beneficiaries entering and leaving HMOs. Our final report will address any necessary corrective actions.

APPENDIX I

SUMMARY OF DISPOSITION OF DENIED PART B CLAIMS FOR BENEFICIARIES WITH DENIALS OVER $5,000

A summary of the disposition of the denied part B claims for the 64 beneficiaries with denials of over $5,000 each for the four HMOs follows.

SUMMARY OF DENIED PART B CLAIMS FOR IMC ENROLLEES

Of the $338,902 in billed charges that were denied by Blue Shield for the 42 IMC enrollees, we identified about $74,150 that were apparent duplicate denials--that is, claims for the same services submitted more than once and denied each time--including about $2,420 in claims that were allowed and later denied or denied and then allowed.[1] This resulted in net denied claims of about $264,750, of which claims for about $144,015 could be located at IMC.

As of October 31, 1984, the disposition of these denied part B claims was as follows:

	Billed charges
Paid by IMC	$113,790
Under review by IMC	24,130
Paid by beneficiary or family	37,580
Paid by other health insurance	2,150
Retroactively disenrolled by HCFA so that regular Medicare should pay	11,980
Part A services, billed under part B, status of bills is unknown	10,270
Other	6,930
Total	$206,830

[1]We found an additional $11,123 in submitted charges for services provided while the 42 beneficiaries were enrolled in IMC and where Blue Shield incorrectly paid a portion of the charges; however, those claims had been paid when originally submitted and, thus, were not included in the denials.

We contacted the applicable providers about the remaining $57,920 in denied part B claims and were told that about $53,680 had not been paid. We did not determine the status of the remaining $4,240. In some cases we could not identify the providers from the Blue Shield printout so we could not contact them, or we did not contact providers with claims of $60 or less. Case studies of 7 of the 42 IMC enrollees are included in appendix II.

SUMMARY OF DENIED PART B CLAIMS FOR AV-MED ENROLLEES

Of the $84,755 in billed charges that were denied by Blue Shield for the 11 AV-MED enrollees, we identified at least $33,896 that were apparent multiple denials of claims for the same services, including $30,225 in claims that were submitted and denied two or more times and $3,671 in claims that were denied and then allowed. This resulted in net denied claims of $50,859, of which we found records on $46,802 at AV-MED. Also, Blue Shield incorrectly paid claims with submitted charges of $7,622 for the 11 AV-MED members while they were enrolled in the HMO.[2]

The disposition of the $50,859 of denied part B claims is summarized as follows:

Paid by AV-MED	$34,441
Paid by beneficiary or family	1,250
Paid by other (unidentified payee)	1,133
Under review by AV-MED	788
Part B services billed and paid under part A	2,483
	$40,095

For the remaining $10,764 of denied part B claims, we contacted the providers and were told that about $9,477 had not been paid. We did not determine what happened to the remaining $1,287 for various reasons. For example, in some cases the provider could not be identified or contacted, and providers with small claims were not contacted.

Case studies of 3 of the 11 AV-MED enrollees are included in appendix II.

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[2]Of the $7,622 in submitted charges, Blue Shield allowed $5,164.

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SUMMARY OF DENIED PART B CLAIMS FOR CAC ENROLLEES

Of the $82,962 billed charges that were denied by Blue Shield for the nine CAC enrollees, we identified $33,691 that were apparent multiple denials (the claims were submitted and denied two or more times), which resulted in net denied claims of $49,271, of which only about $17,162 could be located at CAC. However, upon resubmission, Blue Shield incorrectly paid claims with billed charges of about $7,583,[3] leaving $41,688 to be accounted for. We found that CAC had paid doctor bills with submitted charges totaling about $11,963, leaving about $29,725 in unpaid part B claims.

We contacted 20 providers with outstanding balances of $18,428 and were told that one beneficiary had paid $280. Bills for $310 had been sent to collection agencies. The remaining balance of $17,828 either had been written off as bad debts or was carried as accounts receivable. Five of the providers mentioned that they were not aware that the beneficiaries were members of an HMO at the time they provided the services. When it became apparent to us that CAC enrollees having substantial denied part B claims were not paying the bills themselves, we stopped contacting the providers. Case studies of two of the nine CAC enrollees are included in appendix II.

SUMMARY OF DENIED PART B CLAIMS FOR HEALTH CARE OF BROWARD ENROLLEES

The $15,935 in billed charges that were denied by Blue Shield were applicable to two enrollees. The HMO settled all but $1,720 of the claims which had not been received from Blue Shield or the providers. In one case the HMO had authorized the services, and the claims apparently had been submitted to Blue Shield in error. In the other case, the HMO settled the claims because of apparent confusion concerning the beneficiary's enrollment status.

Case studies of the two Broward enrollees are included in appendix II.

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[3]We identified an additional $8,944 in submitted charges for services provided while the nine beneficiaries were enrolled in CAC and where Blue Shield incorrectly allowed a portion of the charges; however, these claims had been paid when initially submitted and, thus, were not included in the denials.

CASE STUDIES OF SELECTED

BENEFICIARIES WITH DENIED PART B

CLAIMS OF OVER $5,000

It is important for the Congress, beneficiaries, and other parties to understand how the enrollment and disenrollment process and the administration of the lock-in feature of the HMO demonstration projects affected individuals. Therefore, we are including case studies of 14 of the 64 beneficiaries (7 from IMC, 3 from AV-MED, 2 from CAC, and 2 from Broward). We have included two cases where the system generally worked the way it was supposed to and included other situations where the HMOs eventually paid for services they did not initially authorize. However, most of the cases illustrate one or more of the five problem areas discussed in chapters 2, 3, and 4. Where applicable, before each case we identify by chapter number the type of problem we are illustrating.

IMC ENROLLEES

Mr. V. - This case illustrates the problem in coordinating with the Medicare intermediary and the HCFA hospital admissions notification response process (ch. 3) and in obtaining out-of-plan services during the disenrollment waiting period (ch. 4).

Mr. V. was 80 years old when he enrolled in IMC on December 3, 1982, with an effective date of January 1, 1983. On January 13, 1983, he signed a disenrollment form indicating as the reason that regular "Medicare [was] better." Mr. V.'s disenrollment was effective February 1, 1983. According to Blue Shield and Blue Cross claims records, he began seeing other doctors and was hospitalized on the same day he signed the disenrollment form (January 13, 1983).

According to his out-of-plan providers, Mr. V. had a urinary retention (blockage) problem and had gone to the IMC center for assistance and obtained drugs to relieve the condition. When the problem persisted, the IMC center advised him to wait and let the medication work. Because he could not tolerate the pain, he disenrolled and went to private doctors for assistance. On January 17, 1983, he underwent surgery to relieve the problem.

For services during the month of January 1983, Blue Shield correctly denied $6,041 in part B claims for services provided to Mr. V., of which $3,123 was duplicate denials--that is,

claims for the same services submitted and denied more than once--leaving a balance of $2,918 in provider bills, which were the responsibility of Mr. V. because he still was considered as enrolled in IMC. We learned from the providers that Mr. V. had paid $2,003 of the bills, including $1,000 to his surgeon, who accepted this as payment in full for his $1,600 charge. According to the providers, Mr. V. still owed $223. IMC paid $18 to one provider, and we could not determine the status of the remaining $75.

Although the part B claims were correctly denied, the part A intermediary (Blue Cross) on September 5, 1983, paid about $4,381 for Mr. V's hospitalization for January 13 to 24, 1983, while he was still enrolled in IMC. This occurred because when Blue Cross sent the notice of admission to HCFA, it was advised on or about January 18, 1983, that Mr. V. was not enrolled in an HMO. According to HCFA, this incorrect response could have occurred because his January 1, 1983, effective enrollment date had not been annotated on the Health Insurance Master Record until sometime after the admission notice was processed. Although IMC did not authorize this admission nor was there any evidence that Blue Cross determined it was an "emergency," Mr. V.'s hospital bill was charged to IMC for deduction from its capitation payments when Blue Cross sent information on the paid bill to HCFA in September 1983.

Mr. V. requested re-enrollment with IMC on May 13, 1983, at the same center shown on the December 1982 application and, according to IMC records, was reactivated effective July 1, 1983. Mr. V. signed another disenrollment form on August 4, 1983, which indicated that he was dissatisfied with the plan. This disenrollment was effective September 1, 1983; however, on January 4, 1984, Mr. V. again re-enrolled with IMC but requested that he receive services at another IMC center.

Mr. C. S. - This case illustrates the problems in coordinating the denied claims with the Medicare carrier (ch. 2) and the uncertain status of beneficiaries who are in the hospital on their effective enrollment date (ch. 4).

Mr. C. S. was 75 years old when he was enrolled in IMC effective February 1, 1984. According to his wife, he did not intend to enroll and was only requesting information. However, we obtained an application and "Statement of Understanding" apparently signed by Mr. C. S. dated January 10, 1984. On January 25, 1984 (6 days before the effective date of his enrollment), he was hospitalized with a stroke and was in a coma when he became a member of IMC.

When Blue Cross sent the notice of admission to HCFA, it was correctly advised that Mr. C. S. was not a member of an HMO on the date of this admission. Mr. C. S. was hospitalized from January 25, to April 11, 1984; and Blue Cross paid $16,945 of his hospital bill under regular part A, and Mr. C. S.'s private insurance paid $1,810 even though he was a member of an HMO during most of this period.

Blue Shield denied $15,779 in claims for part B services provided during February, March, and April 1984, of which we concluded that $5,149 was previously denied and resubmitted claims, leaving a balance of $10,630 in denied part B claims.

In October 1984 (6 to 8 months after the services were provided), IMC paid $9,377 of Mr. C. S.'s doctor bills. IMC had not received the remaining $1,253 in denied Blue Shield claims and therefore could not have paid them. We contacted a number of the providers and learned that about $853 had not been paid, $175 should not have been billed to Mr. C. S. at all, and the status of $225 could not be determined. IMC paid an additional $1,600 to providers for claims that were not included on the Blue Shield printout of denied and allowed claims. On April 13, 1984, Mr. C. S.'s wife disenrolled him from IMC. The disenrollment was effective May 1, 1984, although she had requested a retroactive disenrollment to February 1, 1984. According to HCFA personnel, they were planning to retroactively disenroll Mr. C. S. so that his doctor bills could be paid by the regular Medicare program, but when we informed them that IMC had paid most of Mr. C. S.'s doctor bills in October 1984, the retroactive disenrollment was not processed.

Mr. F. - This case also illustrates the problem in coordinating denied claims with the Medicare carrier (ch. 2) and the uncertain status of beneficiaries who are in the hospital on their effective enrollment date (ch. 4).

Mr. F. was 79 years old when he enrolled in IMC on January 12, 1984, with an effective date of February 1, 1984. On January 24, 1984, Mr. F. was hospitalized, and on January 25 he requested disenrollment apparently through his wife because he "did not thoroughly understand [the] plan." Because Mr. F. was admitted to the hospital before he became a member of the HMO, Blue Cross paid $6,610 for his hospitalization for January 24 to March 5, 1984, under the regular Medicare program. However,

under the system[1] the disenrollment was not effective until March 1, 1984, and Blue Shield denied Mr. F.'s part B claims for services provided during February 1984.

These denied claims totaled $5,867, of which $120 was a duplicate charge, leaving a balance of $5,747. We contacted the providers and learned that the entire amount was paid by Mr. F. (who had died in July 1984) or his wife. According to the providers, they did not know that Mr. F. was a member of an HMO, and since the claims were unassigned,[2] the providers had never submitted them to Blue Shield. Therefore, we assume that the claims denied by Blue Shield in March and April 1984 had been submitted by Mr. F. and that he had been advised that the claims had been transferred to the HMO.

However, we could not locate any of these claims at IMC, and according to IMC personnel, nobody had approached them to assume responsibility for the bills incurred by Mr. F. during the month he was a member of the HMO.

Under the circumstances of his enrollment and disenrollment, we believe that equity requires that HCFA should assure that Mr. F.'s part B claims are reexamined by IMC or the carrier.

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[1]As the enrollment and disenrollment system is supposed to work under the demonstration projects, a person who requests enrollment before the middle of a month can be enrolled effective the first of the next month. Similarly, a person who requests disenrollment by the middle of the month can be disenrolled at the first of the next month. Requests for enrollment or disenrollment after the middle of the month do not become effective until the first of the month following the next month.

[2]Under part B of Medicare, claims can be either assigned or unassigned. When claims are assigned, payment is made to the provider, who agrees to accept Medicare's allowed charge as the full charge. If the claims are unassigned, payment is made to the beneficiary, who is responsible for the difference between the provider's charge and the Medicare allowed charge. The beneficiary is responsible for the deductible and coinsurance amounts under both methods.

Mr. S. - In this case, except for a problem of some relatively small incorrect payments by Blue Shield (ch. 2), the system appeared to work the way it was supposed to.

Mr. S. was 67 years old when he was enrolled in IMC effective July 1, 1983. On October 7, 1983, he was hospitalized on an emergency basis, and on October 9 he died. Blue Shield incorrectly allowed $218 for part B claims totaling $410 and correctly denied claims totaling $6,307. Of this amount, we concluded $1,200 was either denials of resubmitted claims or amounts that should have been included in the hospital bill, leaving a balance of $5,107 of denied part B claims to be accounted for. Of this amount, Mr. S.'s family paid $150, and IMC settled the remaining $4,957 by paying the providers $3,328.

Also, IMC settled another $750 of Mr. S.'s doctors' bills which had not been submitted to Blue Shield by paying the provider $450.

When Blue Cross sent the notice of Mr. S.'s hospital admission to HCFA, it was correctly advised that he was a member of IMC. In February 1984, Blue Cross paid the hospital $5,666, which excluded the $304 part A inpatient deductible. IMC had a record of the Blue Cross payment, and in accordance with the plan's benefits, the HMO paid the deductible. Also, we located the Blue Cross payment on HCFA's bill itemization lists to be charged against IMC's capitation payments.

Thus, except for the $218 incorrectly allowed by Blue Shield and the $150 paid by the enrollee's family, IMC settled all the identified claims associated with Mr. S.'s illness.

Ms. R. This case illustrates the problems in coordinating denied claims with the Medicare carriers (ch. 2) and in coordinating with the Medicare intermediary and HCFA admission notification process (ch. 3).

Ms. R. was 69 years old when she enrolled in IMC on November 14, 1983, effective January 1, 1984. However, on January 14, 1984, she signed a disenrollment form stating she wanted her own doctor. The disenrollment was effective February 1, 1984. On January 28, she was admitted to a hospital through the emergency room as a result of an accident. Blue Shield denied part B claims totaling $7,279 for services provided for January 28 through January 31, 1984, of which we concluded $2,551 were denials of resubmitted, previously denied claims, leaving a balance of $4,728 in provider bills to be accounted for.

IMC settled the emergency room doctor's $110 claim for $82 on May 9, 1984, and in September 1984 (7 months after the services were provided) paid another $3,727 in claims, leaving $891 in denied claims to be accounted for which could not be located at IMC. We contacted the provider who was owed $800 of the $891 and learned that the claim had not been paid, although it probably would be if Blue Shield transferred the claim to IMC. Therefore, we suggested that the provider submit the claim directly to IMC, which the provider did, and IMC paid it.

According to Blue Cross records, when it sent the notice of admission to HCFA, it was incorrectly advised that Ms. R. was not a member of an HMO. On August 13, 1984, Blue Cross paid the hospital $1,735, excluding the $356 part A deductible which IMC should pay, but had not as of October 22, 1984, because it had not received any notification from Blue Cross regarding its payment. We believe that IMC was not notified because Blue Cross records did not show that Ms. R. was a member of IMC. However, when Blue Cross sent information on the paid bill to HCFA, the payment was charged to the HMO for deduction from its capitation payments in October 1984.

Mr. T. S. - This case illustrates the problem in coordinating with the Medicare intermediary and the HCFA admission notification process (ch. 3) and in obtaining out-of-plan services during the disenrollment waiting period (ch. 4). It also shows that substantial costs can be incurred by the regular Medicare program by the "retroactive" disenrollment of HMO members.

Mr. T. S. was 67 years old when he enrolled in IMC on December 12, 1983, with an effective date of February 1, 1984. On February 15, 1984, he requested disenrollment from IMC, which became effective March 1, because of a desire to stay with his own doctor. According to his disenrollment interview, Mr. T. S. never used any IMC services.

For part B services provided during February 1984, Blue Shield incorrectly allowed $100 and correctly denied $6,152. IMC paid claims of $180, leaving a balance of $5,972 to be accounted for. In October 1984, we contacted a number of his providers and were told that Mr. T. S. had paid $475 of the doctors' bills and that they had a letter from HCFA indicating that Mr. T. S. was to be retroactively disenrolled from IMC effective February 1, 1984. Presumably, the $6,152 in denied claims for part B services provided to Mr. T. S. while he was a member of the HMO will be processed and, if paid, will be charged to the regular Medicare program.

He was hospitalized from February 16, 1984 (the day after he requested disenrollment from IMC), until March 10, 1984. According to Blue Cross records, when it sent the notice of admission to HCFA, it was incorrectly advised that Mr. T. S. was not a member of an HMO, although technically he was until March 1, 1984. On April 13, 1984, Blue Cross paid $12,118 for this hospital stay. The hospital admission was not authorized by IMC. We could not locate this payment on HCFA's bill itemization lists to be charged to the HMO for deduction from its capitation payments--presumably because Mr. T. S. was to be retroactively disenrolled to February 1, 1984, so that the costs of his hospital stay could be charged to the regular Medicare program.

Ms. B. - This case illustrates the problem of incorrect part B payments by Blue Shield (ch. 2). In addition, it shows how beneficiaries can be confused concerning their enrollment status.

Ms. B. was 67 years old when she apparently enrolled in IMC on December 22, 1982, with an effective date of February 1, 1983. However, at the time she enrolled in the demonstration project, she was not eligible for HMO membership because she did not enroll in Medicare part B until July 1, 1983. In February 1983 HCFA advised IMC that her enrollment could not be effective until July 1, but IMC did not adjust its records. Blue Shield incorrectly paid claims with submitted charges of $854 for part B services provided during the period May 27 through June 30, 1983. These payments were incorrect because Ms. B. was not enrolled in part B. In addition, for services provided from July 1 through August 9, 1983, Blue Shield incorrectly paid claims with submitted charges of $484. These payments were incorrect because during this period Ms. B. was a member of an HMO. In addition, for services provided during May 27 through August 17, 1983, Blue Shield denied claims with submitted charges totaling $5,069, of which $1,212 was denials of resubmitted claims, leaving a balance of $3,857 to be accounted for.

On June 17, 1983, Ms. B. advised IMC that she did not and could not belong to an HMO under any circumstances. However, she refused to sign a disenrollment form that requested a July 1, 1983, effective disenrollment date. Thus on August 4, 1983, IMC processed a disenrollment form on her behalf which became effective September 1, 1983. Of the $3,857 in unpaid part B claims, we learned that Ms. B. had private insurance which settled $1,323, leaving $2,534 outstanding. We were advised by the providers that at least $2,456 of these bills had not been paid as of October 1984.

IMC had paid none of her claims and in February and April 1984 specifically denied claims of $1,815. The remaining claims denied by Blue Shield could not be located at IMC.

During the period IMC records showed Ms. B. was enrolled, she was hospitalized three times: from May 27 to June 3, 1983; July 1 to July 21, 1983; and August 1 to August 18, 1983. According to Blue Cross records, when it sent the notice of the May 27 admission to HCFA, it was advised that Ms. B. was to be a member of IMC effective July 1, 1983. On July 6, 1983, Blue Cross paid about $1,696 for the May admission, and according to the hospital, Ms. B. paid $592. The bills for the July 1 and August 1, 1983, admissions were denied by Blue Cross because the admissions were not authorized by IMC and the response from HCFA correctly advised that she was a member of the HMO. According to the hospital, however, the bills for the July and August admissions were paid by Ms. B.'s private insurance ($8,537). The hospital was carrying a balance due from Ms. B. of $258 for these hospital stays.

In summary, during the 7-month period that IMC records showed that Ms. B. was enrolled in the HMO, she incurred medical expenses of $16,278. The regular Medicare program paid for $3,034, her private insurance covered $9,860, and Ms. B. paid about $592, leaving a balance of $2,792 due to the part B providers and the hospital. Because this beneficiary contended that she never was a member of IMC, she did not obtain her services through IMC, and the HMO has paid nothing.

AV-MED ENROLLEES

Ms. Z. - In this case, except for the problem of coordinating denied claims with the Medicare carrier (ch. 2), the system generally worked the way it was supposed to. However, this beneficiary was indigent, and the cost of the out-of-plan services totaling about $7,797 have been absorbed by her providers.

Ms. Z. was a 61-year-old disabled Medicare beneficiary who was also eligible for Medicaid when she enrolled in AV-MED on January 12, 1983, with an effective date of February 1, 1983. According to Blue Shield records, she began seeing out-of-plan providers on March 2, 1983. However, the earliest date that her part B claims were denied by Blue Shield was May 24, 1983, or over 2 months later. AV-MED thus did not have timely information that this beneficiary was going out-of-plan in order to remind her of the "lock-in" provision. For services provided from March 2 to July 11, 1983, Blue Shield denied claims of $5,354, of which we concluded $2,959 were duplicate denials,

leaving about $2,395 to be accounted for. Of the claims denied by Blue Shield, we found $1,909 at AV-MED. The HMO also denied them because the services had not been authorized by her primary care physician. According to Blue Shield and AV-MED claims records, she had not seen the primary care physician shown on her enrollment form while she was a member of the HMO.

According to Blue Cross, Ms. Z. was hospitalized from May 8 to 20, 1983, with a bill of about $5,403. When Blue Cross sent the admission notice to HCFA it was correctly advised that Ms. Z. was an HMO enrollee. On August 15, 1983, Blue Cross rejected the hospital bill, and AV-MED had no record of the bill.

On July 11, 1983, Ms. Z. disenrolled from the HMO with an effective date of August 1, 1983, stating as the reason that she had changed doctors.

In summary, during the 6-month period she was enrolled in AV-MED, Ms. Z. had incurred about $7,797 in medical and hospital bills, of which neither the regular Medicare program nor the HMO had paid anything. We contacted her providers and were told that none of the bills had been paid.

Ms. C. - This case illustrates the problem of incorrect part B payments (ch. 2) and the lack of coordination with the Medicare intermediary and the HCFA admission notification process (ch. 3).

Ms. C. was 71 years old when she enrolled in AV-MED on June 25, 1983, with an effective date of August 1, 1983. According to Blue Cross records, she was hospitalized from September 2 through October 1, 1983.

When Blue Cross sent the admission notice to HCFA, the intermediary was incorrectly advised that Ms. C. was not a member of an HMO. After receiving updated information from HCFA, and determining the admission was an emergency, Blue Cross paid the hospital $10,188 in January 1984, although there is no record that AV-MED had authorized the admission nor did the HMO pay her inpatient deductible of $304, which it should have paid if the services were "in plan." We could not locate this Blue Cross payment on HCFA bill itemization lists so that it was not charged against the HMO's capitation payments.

For part B services provided from September 1 to 26, 1983, Blue Shield incorrectly allowed $2,610 on submitted charges of $3,250. According to Blue Shield, those claims were processed correctly in accordance with information received from HCFA,

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which gave no indication of her HMO enrollment. According to the carrier, it did not receive the correct enrollment information until January 30, 1984, or 6 months after Ms. C.'s effective enrollment date of August 1, 1983.

For part B services provided for September 4 to 17, 1983, Blue Shield correctly denied $5,453 in submitted charges, of which we concluded $3,586 were duplicate denials and $6 was denied and allowed, leaving $1,861 to be accounted for. Of these, AV-MED subsequently paid $1,170 to settle a doctor bill for $1,725 for inpatient hospital services provided on September 7 and 9, 1983. We believe that this payment is inconsistent with the fact that AV-MED did not authorize and was not charged for the cost of the related hospital admission.

According to the claim, the principal service involved surgery related to renal (kidney) failure. While she was still in the hospital, Ms. C. signed a disenrollment form on September 16, 1983, requesting retroactive disenrollment to August 1, 1983. The reason given was "renal disease - needs dialysis." The actual effective date of disenrollment was October 1, 1983.

Mr. W. - In this case the HMO enrollee's hospitalization was handled correctly in accordance with HCFA's instructions but the related doctor bills were not (ch. 2). Also, in this case a doctor was paid by Blue Cross and AV-MED for the same services.

Mr. W. was 66 years old when he enrolled in AV-MED April 4, 1983, with an effective date of May 1, 1983. On July 25, 1983, he disenrolled from AV-MED with an effective date of September 1, 1983. According to his disenrollment form, he wanted to remain with his present doctor. According to Blue Shield records, it correctly denied $169 in claims for part B outpatient services provided between July 25 and August 16, 1983. AV-MED also denied $110 of those claims but paid $55 to settle a claim for $59. On August 27, 1983, or 5 days before the effective date of his disenrollment from AV-MED, Mr. W. was hospitalized for back surgery. This admission was authorized by AV-MED, and when Blue Cross sent the admission notice to HCFA, the intermediary was correctly advised of his membership in the HMO.

For part B services provided in the hospital on August 27 and 28, 1983, Blue Shield correctly denied $5,291 in submitted charges but subsequently settled $3,665 of those claims plus an additional $707 not previously denied for a total of $4,372 in submitted charges, of which Blue Shield incorrectly allowed $2,554. Of the balance of $1,626 in denied claims ($5,291 less

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$3,665), AV-MED subsequently paid $826, but the remaining $800 claim could not be located at AV-MED. AV-MED also settled the $3,665 claim previously paid by Blue Shield for $2,376, which resulted in a duplicate payment to this provider.

Blue Cross paid $1,345 of Mr. W.'s hospital bill for August 27 through 31, 1983, while he was a member of the HMO. We located this bill on HCFA's bill itemization lists to be deducted from AV-MED's capitation payments. Also, AV-MED had a record of the Blue Cross payment and paid Mr. W.'s part A inpatient deductible of $304.

In summary, while Mr. W. was a member of AV-MED the HMO covered all his hospital costs of $1,649. In addition, he incurred $6,167 in doctors' bills, of which Blue Shield paid $4,372, leaving a balance of $1,795. AV-MED settled claims for $4,550, of which $3,665 duplicated the claims paid by Blue Shield, leaving $885 in unduplicated denied claims which AV-MED paid. Of the balance of $910 ($1,795 less $885) in claims denied by Blue Shield, AV-MED also denied $110, of which $35 was paid by Mr. W. and $75 was written off as uncollectible. The remaining $800 in denied claims involving assistance at surgery could not be located at AV-MED, but AV-MED probably would have paid it because the HMO paid other doctors' claims that it received associated with Mr. W.'s hospitalization.

CAC ENROLLEES

Mr. R. - This case illustrates the problems in incorrect part B payments by Blue Shield (ch. 2) and in obtaining out-of-plan services during the disenrollment waiting period (ch. 4). In addition, in responding to the hospital admission notice, HCFA identified Mr. R. in the wrong HMO.

Mr. R., a 70-year-old beneficiary, was a member of IMC from August 1, 1982, through May 1, 1983. His disenrollment form states, as the reason for leaving, the lack of interest on the part of IMC doctors. During this period, Mr. R. incurred out-of-plan services of $80, which were correctly denied by Blue Shield because of his HMO membership. On March 30, 1983, he applied for membership in CAC which became effective May 1, 1983. According to a statement by Mr. R., after enrolling, he visited a CAC clinic complaining of shortness of breath and chest pains and was referred to another doctor at the clinic. According to Mr. R., he was told that he would have to wait over a month to see this doctor. Therefore, he signed a disenrollment form on May 9, 1983, with an effective date of June 1, 1983. According

to Blue Shield claims records, he was seen by a number of out-of-plan doctors on and after May 9, 1983, and was admitted to the hospital on May 11 for heart surgery and was discharged June 10.

During the 1-month period he was a member of CAC, Mr. R. incurred doctors' bills totaling $12,185 and hospital bills of $23,995, which, according to the hospital, had not been paid by Medicare (Blue Cross), the HMO, or Mr. R. as of October 1984. The hospital had requested Blue Cross to pay the portion of the bill incurred through May 31, 1983, but on May 3, 1984, Blue Cross denied the request because the admission was not considered an emergency. In January 1984 Blue Cross paid the hospital $3,548 for the portion of his hospital stay from June 1 to June 10, 1983, but in June 1984 the intermediary recovered this payment from the hospital.

Some of Mr. R.'s doctors' bills were initially denied by Blue Shield, but during August 9 through October 18, 1983, Blue Shield incorrectly paid claims representing $9,830 of the $12,185, leaving a balance of $2,355. According to its records, CAC paid nothing and on October 20 and November 3, 1983, specifically denied three claims totaling $2,905. Of the amounts denied by CAC, $1,510 was incorrectly paid by Blue Shield, and the remaining $1,395 was included in the unpaid balance of about $2,355. According to the providers, these amounts were either still outstanding or had been written off as uncollectible. The reason for the CAC denials was that the services were rendered without referral or authorization by CAC.

In summary, during May 1983, when Mr. R. was a member of an HMO, he incurred medical bills totaling about $36,180, of which the regular Medicare program incorrectly allowed billed charges of $9,830 and about $26,350 was owed to the providers by Mr. R. or was written off as uncollectible. The HMO paid nothing.

In the 15 months following his disenrollment, Mr. R. incurred hospital bills of $15,221 and doctors' bills of $13,071, of which Blue Shield allowed $9,700. The capitation payments to the HMO for Mr. R. for the 15-month period would have been $4,030.

Ms. G. - This case illustrates the problems of incorrect part B payments by Blue Shield and in coordinating denied claims with the Medicare carrier (ch. 2). It also illustrates a situation where an HMO paid for services although it did not authorize them. Also in this case a doctor was paid by Blue Shield and CAC for the same services.

Ms. G. was 66 years old when she enrolled in CAC on October 15, 1982, with an effective date of November 1, 1982. On November 3, 1982, she disenrolled from CAC with an effective date of December 1, 1982. On November 16, 1982, she was hospitalized for surgery. Blue Cross had no record of this admission. She was discharged on November 25, 1982, with a hospital bill of $9,342. Although the admission was not authorized by CAC, the HMO paid the hospital bill. During this period, Ms. G. incurred doctors' bills of $7,550 which were sent to Blue Shield. During January and February 1983, Blue Shield incorrectly paid bills representing $4,305 of the $7,550, leaving $3,245 which Blue Shield denied. CAC settled $1,075 of the denied claims for $994.

In addition, CAC settled $3,400 of Ms. G.'s surgery bills for $1,858, although subsequently Blue Shield allowed $2,520 for these same services, which represented a duplicate payment to the provider. This left $2,170 in unpaid bills owed by Ms. G. We contacted the out-of-plan providers and learned that (1) nothing had been paid and (2) the providers assumed the bills had been transferred to an HMO because Blue Shield's denial notices said they were. However, our review of CAC files indicated that the HMO had not received these claims. If it had, CAC probably would have settled them because it had paid for other services associated with Ms. G.'s hospitalization while she was enrolled.

HEALTH CARE OF BROWARD ENROLLEES

Mr. M. - This case illustrates the problem of coordinating denied claims with the Medicare carrier (ch. 2) and to some extent the problem of coordinating with the Medicare intermediary and the HCFA admission notification process (ch. 3).

Mr. M. had been a member of the HMO from March 1, 1982, to September 1, 1983, when he was listed as deceased. Blue Shield had denied claims of $9,129 for services provided from March 28 to August 6, 1983, of which $8,638 were paid by the HMO because it had authorized the services, leaving $491 in denied claims which could not be located at Health Care of Broward.

Our analysis of the $8,638 in claims paid by the HMO indicated that they had been received directly from the providers rather than transferred from Blue Shield. Of the $8,638, the claims for $3,052 were dated after the claims had been denied by Blue Shield, which indicated that after the denials the providers had billed the HMO. The claims for $5,586 were billed to the HMO and were dated before the date the claims had been

denied by Blue Shield, which indicates to us that these providers may have billed both the HMO and the regular Medicare program for the same services. In addition, we found $10,570 in paid part B type claims for the member at the HMO that had not been submitted to Blue Shield.

According to Blue Cross records, Mr. M. was hospitalized twice while he was a member of Broward. The first admission covered from June 17 to 29, 1983, and HCFA's response to the admission notice correctly identified him as a member of the HMO. On August 8, 1983, Blue Cross paid $4,617 for this admission. The HMO had authorized the admission and had a record of the Blue Cross payment. For the second hospital admission covering July 20 to August 6, 1983, HCFA's response to the admission notice did not identify Mr. M. as an HMO member. Because the hospital claim included an HMO authorization number, Blue Cross paid $6,507 for this admission on August 31, 1983. However, Broward had authorized the admission and also had a record of the Blue Cross payment so that there was no potential adverse effect resulting from the incorrect or incomplete response.

The unresolved potential problem is that neither we nor the HMO could locate those Blue Cross payments made on behalf of Broward on HCFA's bill itemization lists, which could result in the payments for authorized services not being charged against the HMO's capitation payments.

Ms. T. - This case illustrates the problem of coordinating denied claims with the Medicare carrier (ch. 2). It also illustrates a situation in which an HMO has assumed responsibility for unauthorized services because of apparent confusion concerning a beneficiary's enrollment status.

On March 22, 1983, 69-year-old Mr. T. enrolled himself and his 65-year-old dependent spouse Ms. T. in one of the HMO's private group employer plans with an effective date of April 1, 1983.[3] On April 13, 1983, Mr. and Ms. T. also enrolled in the Medicare demonstration project at Health Care of Broward effective May 1, 1983, apparently on the assumption it was supplemental to the private health insurance obtained through the employer.

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[3]Under section 116 of TEFRA effective January 1, 1983, employers must provide that any employee (or the spouse) ages 65 through 69 shall be entitled to coverage under any group health plan and that Medicare payment would be secondary to or supplement the benefits under the private group plan.

In July 1983, Mr. T. retired and advised his employer that he would seek Medicare supplementary insurance other than through Broward. However, the employer did not advise Broward of this situation until January 13, 1984. Mr. and Ms. T. were disenrolled from the employer group plan effective December 1, 1983. Mr. T. was disenrolled from the HMO Medicare plan effective December 1, 1983, but Ms. T. was apparently not disenrolled until September 1, 1984. During July 20 through October 5, 1983, Ms. T. incurred doctors' bills totaling $6,806 which were denied by Blue Shield. We located $5,577 of these claims[4] at Broward, of which $3,203 was initially denied by the HMO because prior authorization for treatment was not given by an HMO physician.

In October 1984, however, Broward was attempting to settle the $5,577 in claims on behalf of Ms. T. because of the confusion involving the member's enrollment and disenrollment in both the Medicare demonstration project and the HMO's private employer plan. The remaining $1,229 in denied claims were not included in the settlement because the HMO had not received them from Blue Shield.

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[4]Our analysis of these claims showed that they had been addressed to Medicare and were dated before they had been denied by Blue Shield, which indicates to us that they could have been transferred to the HMO from Blue Shield.

(106262)

APPENDIX 2

SUBMITTED FOR THE RECORD BY FRANK SEUBOLD, PH.D., AT THE REQUEST OF CHAIRMAN PEPPER

OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS—BUDGET HISTORY—FISCAL YEARS 1980–86

[Dollars in thousands]

Appropriations	1980	1981	1982	1983	1984	1985	1986 [1]
Grants	$43,813	$8,800					
Loan fund [2]			$17,500	$2,650			
Management training/technical assistance	1,500	1,500	480	480			
Program support	9,077	9,937	4,169	4,702	$4,622	$4,225	$4,322
Total appropriated	54,390	20,237	22,149	7,832	4,622	4,225	4,322
Positions—budget authorization (FTP)	184	205	82	74	74	74	74

[1] President's proposed budget
[2] Supplemental appropriations to repurchase defaulted guaranteed loans from the Federal Financing Bank.

Note: 1983–86 program support budget and position figures do not include Bureau overhead associated with HMO activities.

OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS—STAFFING HISTORY—FISCAL YEARS 1980–86

	1980			1981		
	FTP	Other	Total	FTP	Other	Total
Headquarters:						
Office of the Director	23	14	37	23	11	34
Private sector liaison	8	2	10	8	3	11
Division of Analysis and Technical Assistance	25	10	35	25	8	33
Division of HMO Qualification	17	4	21	17	4	21
Division of HMO Compliance	46	5	51	46	2	48
Total	119	35	154	119	28	147
Regional offices	61	4	65	61	5	66
Total staffing	180	39	219	180	33	213
Positions—budget authority	184			[1] 205		

	1982 [2]			1983 [2]		
Headquarters:						
Office of the Director	19	1	20	8	1	9
Private sector liaison	6	1	7	7	2	9
Division of Analysis and Technical Assistance	7	1	8	9	0	9
Division of HMO Qualification	17	3	20	19	2	21
Division of HMO Compliance	33	3	36	31	2	33
Total	82	9	91	74	7	81
Regional offices						
Total staffing	82	9	91	74	7	81

	1984			1985 original		
Headquarters:						
Office of the Director	9	0	9	8	0	8
Private sector liaison	5	1	6	6	1	7
Division of Analysis and Technical Assistance	9	0	9	9	0	9
Division of HMO Qualification	20	2	22	20	2	22
Division of HMO Compliance	31	3	34	31	3	34
Total	74	6	80	74	6	80

OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS—STAFFING HISTORY—FISCAL YEARS 1980–86—Continued

	1980			1981		
	FTP	Other	Total	FTP	Other	Total
Regional offices						
Total staffing	74	6	80	74	6	80
	1985 current [4]			1986 estimate		
Headquarters:						
Office of the Director	8	0	8	8	0	8
Private sector liaison	5	1	6	5	1	6
Division of Analysis and Technical Assistance	7	0	7	7	0	7
Division of HMO Qualification	24	2	26	24	2	26
Division of HMO Compliance	30	3	33	30	3	33
Total	74	6	80	74	6	80
Regional offices						
Total staffing	74	6	80	74	6	80

[1] Positions authorized by Congress; ceiling increase was not granted.
[2] Staffing after 2 reductions-in-force.
[3] Staffing after PHS reorganization. HRSA established Sept. 1, 1982.
[4] Staffing reflects details/reassignments from other components within OHMO to the Division of HMO Qualification to help meet increasing workload.

Note: 1983–86 total staffing figures do not include Bureau overhead related to HMO activities.

OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS—QUALIFICATION AND COMPLIANCE ACTIVITIES, RESOURCES ALLOCATION: FISCAL YEARS 1980–86

[dollars in thousands]

	1980	1981	1982	1983	1984	1985	1986
Division of HMO Qualification:							
Staff positions (FTP)	17	17	17	19	20	24	24
Total budget	$599	$680	$733	$849	$834	$948	$948
Travel allocation	$85	$66	$60	$70	$63	$90	$90
Division of HMO Compliance:							
Staff positions (FTP)	46	46	33	31	31	30	30
Total budget	$1,638	$1,860	$1,438	$1,303	$1,324	$1,412	$1,412
Travel allocation	$137	$93	$50	$33	$52	$37	$37

APPENDIX 3

Statement of the American Federation of Home Health Agencies

Mr. Chairman, my name is Joan Buddi. I am the Vice President of the American Federation of Home Health Agencies, and the Administrator of Home Health of North Broward in Tamarac, Florida. AFHHA appreciates the opportunity to comment on the problems associated with Health Maintenance Organizations participating in the Medicare program.

The HMO concept of a health program offering both comprehensive patient services and cost savings is a commendable one. We do, however, have concerns about the performance of some HMOs, as they put the theory into practice. We will confine our remarks primarily to our observations of HMOs in the South Florida area.

We believe that due to beneficiary confusion, inadequate administrative controls, and questionable HMO policies, some elderly and disabled Americans are not receiving the health care services they need through their HMOs, while others are left with bills for services that they did not realize constituted out-of-plan care. A number of home health and other providers have rendered care to patients only to discover that the costs are not reimbursed because patients were enrolled in an HMO, unbeknownst to the provider.

Our concerns are directed to several aspects of the Medicare HMO demonstration projects in South Florida.

Some HMOs which participate in the Medicare program have used questionable tactics to enroll Medicare patients, including door to door solicitation and signup tables at South Florida condominiums. Confused elderly beneficiaries have signed up for membership in an HMO without the knowledge of family members, and in some cases the beneficiaries have no recollection of enrollment.

Others who believed they were simply requesting information from HMO solictors found themselves members. It seems that HMO recruiters receive a commission for each name added to the rolls but suffer no consequences for disenrollments. Some elderly patients have joined HMOs believing that they were signing up for a program offering them additional health services, such as hearing aides and dentures, not realizing that they can no longer participate in the regular Medicare program or use their long-time physicians.

Many older citizens are enticed by slick HMO advertisements featuring popular entertainers. It is disturbing to see ads which reflect an enormous advertising budget at the same time we are receiving reports of patients unable to obtain the services they need.

The enrollment and disenrollment procedures of the HMOs and HCFA have created further confusion. In a number of cases, home health agencies have provided services to Medicare beneficiaries only to discover either that the patient is an HMO enrollee, or that a beneficiary who had opted out of an HMO is still listed as a member. The provider and patient are left with the bill in such cases. Home health agencies are cost reimbursed and cannot absorb many such losses; and few elderly patients can pay for major health services out of pocket.

At present there is no effective way home health providers can identify HMO enrollees. Members retain their Medicare cards which are not marked in any way to indicate affiliation with an HMO. The lists which HCFA is now making available to identify HMO members understandably lag several months behind. The problem is compounded since some HMOs do not process disenrollments expeditiously and patients on occasion find they are still members months after they opt out.

We are also concerned about the quality of care patients are receiving through some HMOs. In my own agency, I have seen patients in need of home health services enter onto the rolls of HMOs which do not request the patients' records, and in some cases fail to provide essential home care services, e.g. to a patient with a Foley Catheter. No matter the seriousness of the patient's condition, rarely does an HMO member receive more than ten home health visits. We can only conclude that some HMOs are cutting costs by cutting back on care.

To illustrate this problem further, a home health agency in north Dade County has received reports through a physician of an HMO which told a patient with a painful salivary gland tumor that he would have to wait five weeks for an appointment; another patient in need of cataract surgery was instructed to disenroll in the HMO to have her surgery and then re-enroll after the procedure was completed.

We are further concerned that health case services are sometimes not readily available to Medicare HMO members. Patients in need of emergency services have been forced to endure critical delays in obtaining permission from the HMO for out-of-plan care.

Access to services is limited in my own county—Broward County—since there is no HMO-affiliated hospital. Enrollees and their families must travel considerable distances to participating hospitals. In additional, may elderly residents have moved to Florida from other areas of the country and spend considerable time with relatives and friends in their state of origin. They are liable for any medical services received while away and are at risk of their HMO ruling such services non-emergency and therefore not reimbursable.

In their eagerness to sign up participants, HMOs are not fully informing patients of these drawbacks and possible consequences of membership. If the flaws evidenced in the Florida HMOs are not corrected as Medicare beneficiaries enroll in HMOs across the country, many elderly and disabled citizens will be deprived of the health services to which they are entitled.

We urge the following measures to correct some of the glaring flaws:

Marking patient Medicare cards to indicate HMO membership; developing an oversight and quality control mechanism outside of the HMOs; providing greater scrutiny of HMO ads to insure truth in advertising; and conducting a financial audit, by GAO or another entity, to determine the profits of Medicare HMOs and the actual amount spent on patient services.

HMOs are wellness oriented programs. We urge you to look very carefully at the implications of applying this concept to an elderly population where wellness is not the norm, and to take action to insure that elderly and disabled Americans enrolled in HMOs have the same access to quality care as other Medicare beneficiaries.

STATEMENT OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC.

The Group Health Association of America is the major representative of group and staff model Health Maintenance Organizations (HMOs). Our member plans encompass nearly 75% of the national HMO enrollment. Our older plans were the pioneers who proved the ability of prepaid organized health care systems to bring high quality, comprehensive and cost efficient health care to consumers. The comprehensiveness of our benefits and our cost efficiencies derive from emphasis on early access, preventive care, outpatient coverage and the development of utilization review systems designed to avoid unnecessary hospitalization and unneeded medical procedures. Savings generated by these efficiencies are translated into broader services and lower out-of-pocket cost to the consumer.

It is no wonder then, that, in these days of disastrous health care inflation, employers, unions, consumers and government are actively promoting HMO membership. Our enormous growth over the last few years is reflective of this interest.

For many years we led the uphill struggle to bring the advantages of HMOs to the elderly. Medicare, since its enactment, had set a cost reimbursement system for HMOs, thus precluding our ability to pass on savings to the elderly in the same manner as we do for the under sixty-five population. Since 1965, HMO enrollment among the elderly has mainly consisted of those who "age in" to Medicare. These "aged in" enrollees must fill in the Medicare gaps and pay a premium for other benefits normally offered by the HMO. In many cases this results in considerable financial hardship to persons living on fixed incomes.

With the enactment of the Tax Equity and Responsibility Act of 1982 (TEFRA), a new prospective reimbursement system for Medicare services by HMOs and Competitive Medical Plans (CMPs) was initiated. Under TEFRA, HMOs and CMPs who enter into a risk contract with the Health Care Financing Administration (HCFA) received a prepaid capitated amount for each Medicare enrollee on a monthly basis. HMOs will be reimbursed prospectively at 95 percent of the adjusted average per capita cost or AAPCC, that is 95 percent of the fee-for-service cost of providing Medicare Part A and Part B benefits in their geographic area.

The statue further provides that an HMO must calculate its own adjusted community rate (ACR), which is the premium it would need to provide the Medicare benefits to its members. To the extent that the HMO's efficiencies result in an ACR which is lower than the Medicare reimbursement level set at 95 percent of the AAPCC, the HMO must use these savings to provide additional benefits to its Medicare members. These added benefits might take the form of buying out the usual Medicare copayments and deductibles and/or providing services not covered by Medicare, such as outpatient prescription drugs or eyeglasses. TEFRA provides that in addition to the basic Medicare benefits and those which are covered by the savings, HMOs may also provide further supplemental benefits to their Medicare members for which they may charge a premium. Thus, for a limited out-of-pocket cost, Medicare enrollees can have the same comprehensive benefit package which an HMO

offers to its under 65 enrollees. Medicare beneficiaries who join HMOs under this reimbursement arrangement must agree to obtain all of their health care only from or through the HMO. This arrangement is known as a lock-in.

Thus, under TEFRA risk contracts, Medicare beneficiaries will receive additional benefits; HMOs will be appropriately reimbursed; and the government will pay five percent less than fee-for-service Medicare costs.

In order to test this reimbursement system, Medicare entered into a number of demonstration projects. The longest running of which began enrolling members in 1980 and have been highly successful. At the Fallon Community Health Plan in Worcester, Massachusetts, its Medicare members paid a premium of $15 per month for which they received their Medicare benefits plus a variety of additional benefits at no further out-of-pocket cost. Their benefits included unlimited hospitalization, unlimited primary care physician and specialist visits, all laboratory and x-ray services, prescription drugs, unlimited home care, all medical equipment and prosthetic devices, immunizations, biennial eye exams and eyeglasses.

A survey of Fallon's Medicare members conducted in 1981-1982, showed a satisfaction rate of 99 percent. Fallon also found the reimbursement system to be successful from an operational standpoint. The plan was small and had no Medicare members when it first embarked on its Medicare demonstration project. Medicare members were enrolled in carefully planned annual increments with the goal of reflecting the same ratio in the plan as in the surrounding community.

The Kaiser Foundation Health Plan of Oregon was already a well-established 234,000 member plan which was serving Medicare members under a cost-based contract when it began its Medicare demonstration project. It was permitted to convert 1,800 of its existing Medicare members to the demonstration project and to enroll 5,500 Medicare beneficiaries who had not previously been plan members. This demonstration has also been highly successful for both the beneficiaries (with a 93 percent satisfaction rate) and the HMO.

Under the Kaiser project, two benefit packages were offered, both of which covered Medicare Part A and Part B benefits and additional services not covered by Medicare. Under the first benefit option, for a $5 per month premium, benefits included: (1) for no additional charge, complete inpatient and outpatient hospital services (including physicians' and surgeons' services), all laboratory and x-ray services, and home health services; (2) for a $2 copayment per visit, all outpatient physicians' services, most immunizations, physical therapy, and vision and hearing examinations. Under the second benefit option, for a premium of $20.83 per month, enrolled beneficiaries received a benefit package which included all the services just listed plus prescriptions (for $1 copayment), and hearing aids and eyeglasses at no charge.

Both the Fallon and Kaiser Portland projects have demonstrated that under prospective reimbursement at 95 percent of the AAPCC, HMO efficiencies can produce substantially increased health care benefits for the elderly, protection from significant out-of-pocket costs and uncertainty about physician willingness to accept assignment, and freedom from paper work burdens; and that these things can be done within a system that provides high quality, accessible health care. We believe that the availability of HMO coverage following the implementation of TEFRA opens an important new health care option for Medicare beneficiaries at a time when cuts are the order of the day in the Medicare program.

There is no question that this can be a good program for the elderly and for the HMOs which participate in it. However, Medicare beneficiaries can be a vulnerable population, and as was the sad result under the PHP (prepaid health plan) program for Medicaid beneficiaries in California in the late 1970s, if such a program is abused, the results can be tragic.

Many lessons have been learned from the PHP experience, and subsequent efforts have been made to create safeguards which will provide the oversight and enforcement authority needed to prevent harm to the program's intended beneficiaries, but which are not so burdensome of inflexible that legitimate HMOs will not find participation in government programs attractive. The safeguards included in TEFRA range from requirements relating to the structure of the organizations which may participate, to the reimbursement and benefit provisions, to marketing and enrollment standards, and to individual member rights. They have been carefully selected to provide a framework within which the Medicare population can safely and successfully be offered a comprehensive prepaid health care option.

The key to HMO success over the last 40 years has been the element of informed choice. We are particularly sensitive to the care which must be given to education the elderly as to all of the advantages and disadvantages of HMO membership. The TEFRA regulations require that an HMO must maintain and provide its Medicare members with written rules regarding how and where to obtain services from or

through the organization, disenrollment rights, procedures for paying any out-of-pocket costs, and grievance and appeal procedures.

A basic concept of HMOs is that medical services must be obtained directly from the HMO or arranged for or referred by the HMO, unless they are emergency services. This lock-in concept requires effective communication and education of HMO members. Medicare enrollees, in particular, need to be fully informed of the implications of the lock-in provision. An informal GHAA survey of 14 of its member plans participating in Medicare demonstration programs indicated a variety of educational efforts, in addition to marketing brochures, to instruct enrollees about the differences between HMO membership and traditional fee-for-service medical care. These efforts included individual counseling, group orientation programs, special handbooks, hot lines, assigned patient coordinators, open houses, special monthly publications, and follow-up counseling.

Another area of particular concern with respect to the elderly is that of accessibility to emergency services. The TEFRA regulations require that medically necessary emergency services must be available 24 hours a day, seven days a week. The HMO or CMP is required to cover emergency services obtained outside of the plan if they are needed because of an injury or sudden illness and when the time required to reach the organization's providers would cause permanent damage to the patient's health. The services are considered emergency services as long as transfer to the HMO facility or its designated provider is precluded because of risk to the patient's health or the distance involved. However, because HMOs either have their own hospital facilities or have contracts with certain facilities in their areas, they do prefer to provide care in such facilities whenever appropriate.

The assurance of quality of care is a critical component of a sound health care system. Although the establishment of an effective quality assurance program is already a requirement for federal qualification of HMOs and is also a condition for TEFRA contracts, further quality assurance methodology is being developed for peer review of services provided under the risk contracts. The HMO industry is working with the Health Standards and Quality Bureau (HSQB) of HCFA to prepare criteria by which such reviews will be conducted.

The Medicare demonstration projects provided necessary experience with the risk reimbursement system before TEFRA contracts were implemented. The demonstrations showed the many advantages of the program as well as areas where improvements were needed. One of the problems which was encountered was that the processing of HMO enrollments and disenrollments by HCFA was not always completed in a timely or accurate manner. However, it appears that the recordkeeping and processing system has been improved and that the HCFA has made progress in its capability to update enrollment and disenrollment records on a timely basis. This aspect of the program is critical to ensuring that Medicare beneficiaries receive appropriate services in proper settings with a minimum of confusion or delay.

We appreciate the opportunity to provide the perspective of GHAA and its member plans on these issues. As strong proponents of the Medicare risk contract program, we are anxious that it will be successful and beneficial for all concerned—the beneficiaries, the government and the HMOs. We look forward to working with the Subcommittee to assure that the "promising partnership between Medicare and prepaid health plans", as it was so aptly put by the Chairman, will be fulfilled.

FLORIDA ASSOCIATION OF HOME HEALTH AGENCIES, INC.,
May 3, 1985.

Representative CLAUDE PEPPER,
Chairman, Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, House Office Building, Washington, DC.

DEAR REPRESENTATIVE PEPPER: Thank you for your invitation for submission of written comment on our experiences with the Medicare involvement with HMO's. As you indicated in your letter to Jim Cooper, our Executive Director, our organization has a very strong interest in this matter and we appreciate your time and interest.

Attached you will find a packet of documentation compiled from home health agencies across the State enumerating and giving specific case examples of the variety of problems that we are encountering. We would like you to be aware that we are working to resolve these problems on both the state and federal levels.

The first problem that we are encountering lies in enrollment policies of the HMO's. Many of our patients have informed us that they never have joined an HMO. Many state they signed an attendance sheet or sent away for further information, but had not joined the HMO. Others have been mislead to believe that the

HMO benefits are unchanged from the Medicare benefits and in fact that they will receive more service with HMO enrollment, such as "free eyeglasses, free hearing aides and free prescriptions". Additionally, some patients are under the misconception HMO's are a supplement to Medicare. I emphatically state that the Medicare patient is being mislead by the HMO's as to their medical coverages. What we have been experiencing first hand is that the HMO's must offer the same services as Medicare, but in fact, do not authorize the same medical treatment that Medicare patients receive. The end result is medical care for HMO patients is drastically short of the coverages offered under Medicare. Patient care is being compromised both in quality and quantity. We have documented cases where care has either been negligent or less than optimal to return the patient to the state of wellness. As this is a very lengthy and complicated issue, I please request you to refer to the documentation submitted. It is my very strong belief that in the majority of cases, Medicare patients are not good candidates for a HMO system. Their health needs are to taxing for the amount of funds delegated and their illnesses are frequently long term in nature.

To make matters worse, the funds that normally went directly to the patient's personal medical needs are now being divided by the HMO's into administrative costs and medical costs, therefore, the end result is their Medicare dollar is actually shrinking as to the medical services it can provide.

This leads us to our next major problem as a home health industry. There is no uniform way of identifying Medicare recipients as to their HMO enrollment. As we stated earlier, many Medicare recipients are unaware for many reasons that the delivery of their care has been altered when they join an HMO. They do not understand that they must go for all medical attention to that center and have all medical treatment prior authorized. They are under the misconception that they can "shop around" as they have under their normal Medicare benefits. Our first notice as to a patient's HMO enrollment is frequently when our fiscal intermediary returns our bill. At this point, it is too late for us to collect our expenditures as care was not pre-authorized under the HMO system and the HMO's instruct us to bill the patient. I am sure that this is not the intention of the HMO demonstration project. These patients do not have the money to cover the services. We are working on this problem at a State level in Florida. We have an amendment to the House Bill—(SB 573) regulating HMO's that states the HMO will be responsible for putting a sticker on the patient's Medicare card at the time of enrollment as to their HMO enrollment and the effective date. When our patients are soliciting our services, they are currently showing us their Medicare card. They do not recognize additional cards as to their HMO enrollment if any are distributed. Therefore, we have concluded that the only way to identify these HMO enrollees is by marking their Medicare card itself.

Another problem area that is being dealt with on a State level is the disenrollment practices of the HMO's. We are noticing a severe lag time between a patient's request for disenrollment in the HMO system and being put onto the Medicare rolls. Most cases take at least 60 days for the transfer and the patients are frequently left without medical coverages. Once a patient becomes dissatisfied with the HMO enrollment and request disenrollment, the only services provided are emergency services until their Medicare coverage resumes. This has left our elderly population with high medical problems at a terrible risk. Additionally, patients are left on the HMO roster after their disenrollment and at times, are on the roster months after their death. Are the HMO's still receiving Medicare funds for these patients?

Lastly, we are experiencing an incredible delay time between services rendered and bills paid. None of the home health agencies in the State of Florida are receiving timely payments. I don't understand the reason or justification for paying a bill as late as 12 months after services were rendered when the HMO's are receiving their allotment monthly regardless of patient care being rendered by the physician. As you can imagine, this has created a cash flow problem for many providers and in fact, we are noticing a trend in IMC offices filing under Chapter 11. We feel that this issue needs to be addressed.

As I stated in my letter addressed to you on March 22, 1985, as a registered nurse and an administrator of a home health agency, I am greatly concerned for our elderly population. It distresses me to see these people, whose health care needs are so extensive go without the care that they need and deserve. After years of service to us and to our Country, our elderly citizens deserve only the best that we can provide. They do not deserve to be deceived in their health care delivery or, to be shorted medical benefits so executives can pocket the profit and they do not deserve the increased burden of administrative red tape when they are sick and in need.

Once again, thank you very much for your time and your interest. If I can be of any further assistance, in any way possible, please do not hesitate to contact me.

I remain,

Sincerely,

CHERYL H. HUNT, RN,
Chairman, Ad-Hoc Committee on HMO's.

NATIONAL HEALTH LAW PROGRAM, INC.,
Los Angeles, CA, May 13, 1985.

Hearing on "HMOs and Medicare: Problems in the Oversight of a Promising Partnership."

SELECT COMMITTEE ON AGING,
Subcommittee on Health and Long-Term Care, House of Representatives, House Office Building, Washington, DC.

DEAR MR. REINECKE: I would like to supplement my pre-hearing written testimony with the following comments, principally to address some matters raised at the April 24, 1985 hearing. I would appreciate your making this a part of the hearing record.

A. DISENROLLMENTS

We strongly support Congressman Pepper's proposal to appreciably shorten the time period within which disenrollments must become effective. We also support the shorter time period provided for in Congressman Mica's bill, H.R. 2010.

While we applaud HCFA's representation that disenrollments (and enrollments) will now be posted effective the first of the month, we note that this reform is not a substitute for Congressman Pepper's proposal. The agency is saying that a disenrollment properly forwarded to HCFA will be posted without the lag time the GAO Report critiqued. Such posting does not address the time within which requested disenrollments must be effective.[1]

Accordingly, Congressman Pepper's proposal remains extremely important. In addition, other problems in the disenrollment process have not been resolved.

There was unanimous agreement that something must be done to clarify coverage responsibility for out-of-plan services incurred during the "waiting period" between a disenrollment request and its effective date, so that beneficiaries are not personally liable. We applaud the HCFA representatives' indication that they are evaluating options in this area (we assume that this evaluation is not limited to the situation of beneficiaries hospitalized during this period) and hope this will be resolved forthwith. However, this is of no help to the thousands of beneficiaries who have already been victimized by this problem (see Section E, *infra*). Other issues/recommendations noted in my pre-hearing testimony (p. 21) and during the hearing must also be resolved.

B. BENEFICIARY APPEALS AND COMPLAINTS

The HCFA representatives at the hearing insisted that existing beneficiary appeals and complaint-raising systems are adequate. Dr. Seubold cited to the HMOs' required internal grievance processes, complaints to the Office of Health Maintenance Organizations (which is in the Washington, D.C. area), and what he referred to as a "well laid-out appeals process." Dr. Davis referred to the grievance process, and said that beneficiaries can appeal through the "regular Medicare process" and can contact the "beneficiary services" office of local Carriers.

To the extent that these comments sought to convey that there is an adequate, integrated, and well-functioning system in place, I must respectfully disagree.

First, as noted in my pre-hearing testimony (pp. 17-19), the HMO appeals process, through which coverage for out-of-plan services can be secured, has not been imple-

[1] HCFA interprets the statute to provide that a disenrollment may not be effective earlier than the second month after the month of request. In addition, HCFA's new regulation, 42 C.F.R. 417.460(b)(2), allows the HMO 30 days to submit a disenrollment form. As was brought out at the hearing, HMOs could delay submission. The HCFA representative suggested that an HMO's "marketplace" interest would prevent this; however, disenrollments involve an already-dissatisfied person, and the HMO can gain at least a few hundred dollars in capitation payments by delaying.

mented.[2] Despite thousands of instances of the problems it is designed to resolve, it has virtually never been used. Second, the "regular" Medicare appeals process (see 42 C.F.R. 405.700 et seq.; .800 et seq.), is not a substitute. It is similar to the HMO appeals process, offers less protection, and arguably should not even apply to HMO enrollees. Third, these appeals processes resolve coverage decisions months after the fact; neither is suitable for addressing the kinds of beneficiary quality of care complaints Subcommittee members raised at the hearing.

During the hearing, Subcommittee members were concerned over how enrollees with significant complaint could promptly "appeal" to a local, impartial source of help outside the HMO. If the HMO and "regular" Medicare appeals processes are not responsive to this need, what about the other avenue Dr. Davis cited?[3]

The HCFA representatives implied that there is a clear policy that beneficiary complaints should be directed to Carrier Beneficiary Services Offices. This policy was not so clear, for example, to the head of HCFA's Group Health Plan Operation's staff, who, for example, in an April 1985 People's Medical Society article stated that complaints should be directed to local Social Security offices. I have similarly been advised by other HCFA representatives that complaints could be addressed to SSA offices.[4]

With all due respects, I don't think either source is particularly useful for a serious problem monitoring function. In addition, there is reason to believe that they have not yet even been adequately prepared to advise beneficiaries.

After the hearing, in order to check the efficacy of complaints to a Carrier beneficiary services office, I had an aide contact one such office. She made four calls, and asked what could be done about two simple problems highlighed at the April 24 hearing: receipt of unreimbursed "out-of-plan" services; and unreasonable denial of care.[5] In each instance, the advice provided was erroneous, and did not mention any grievance or appeal rights.[6] In addition, reaching this office was not without inconvenience; there were busy signals 7 out of 21 times, and 6 times the number rang for over 1½ minutes without an answer.

It is not my intent to malign the workers at these offices. On the contrary, some expressed great concern, and wanted to be helpful. I am sure they are deluged with a high volume of phone contracts (mostly relating to claims processing). Neither these offices nor the persons who staff the SSA Central Teleclaims phones are available to resolve HMO complaints, and they have plainly not been effectively apprised of the remedies available to beneficiaries.

We reiterate the recommendations made on point in our pre-hearing testimony (pp. 26–27) and also emphatically support Congressman Pepper's suggestion that a mechanism be established whereby a local, impartial ombudsman can receive, investigate, and resolve emergent complaints. It will not be sufficient simply to proclaim that the responsibility has been added to existing offices' workloads.

C. INTERMEDIATE SANCTIONS

The statute and regulations set forth two sanctions which can be employed to remedy HMO misconduct. One is the beneficiary appeals process, which though poorly publicized and little used, is a means by which individual beneficiaries may be able to compel HMOs to pay for some services improperly denied. The other sanction would be to terminate an HMO's Medicare contract, something never done and not likely to be employed except in the most appalling of circumstances.

In response to questioning by Congressman Bohlen, HCFA representatives referred to two other sanctions: forced disenrollments, and "correction plans" ordered following OHMO reviews. Due to time constraints, there was no discussion of the

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[2] Despite the fact that each demonstration HMO about which I obtained the information has never implemented a legal appeals system, HCFA entered into new TEFRA contracts with *all* 26 demonstration HMOs, effective April 1. For many or most, this did not have to be done for at least several more months.

[3] Drs. Davis and Seubold both also mentioned the HMO internal grievance process, but its practical limits for this purpose were acknowledged by the Subcommittee. Parenthetically, I am uncertain about how effectively the HMOs are implementing their grievance procedures, and unaware to what extent HCFA is monitoring that implementation. In addition, I think the OHMO, located in Rockville, Md., is not useful for this complaint-resolving purpose.

[4] Reliance on Social Security offices does, of course, bring up the questions the Committee raised about those offices' capacities in light of potential staffing cuts.

[5] Regarding the latter issue, my aide's story was that her father was in severe, debilitating pain and that his HMO doctor had told him "it was all in his head" and wouldn't do anything.

[6] Three respondents did advise that the person should or could disenroll, which though correct, was hardly responsive to the complaints.

parameters of these sanctions, nor the frequency with which they have been used. Whatever the other limits to their utility which may exists, one significant limit is that they are virtually unknown outside the agency, and so complainants can not request their use.

The situation of HMOs is not unlike that of nursing homes. They are private entities that provide a full range of services to a locked-in beneficiary population in return for monthly government payments. They may be certified as meeting a range of qualifying conditions, and they enter into contracts to be able to serve beneficiaries. Primary sanctions include termination of program participation and imposition of plans of correction.

It would be unwarranted to carry this analogy too far at present; significant dissimilarities exist as well. HMO enrollees do not reside at the HMOs; are not substantially threatened by physical plant and quality of life problems; are far less disabled; and are able to "vote with their feet." Nonetheless, the issues about sanctions are similar, and may well grow in severity as HMO/CMP participation mushrooms.

It would be reasonable to create additional "intermediate sanctions" (i.e., short of contract termination) that could be employed to penalize improper HMO behavior. One such sanction—retroactive disenrollment in cases of improper advertisements—was proposed in our pre-hearing testimony (See p. 16, #4). Others could include fines, suspension of enrollments, publicly-accessible complaint reports, and Orders for reimbursement of out-of-pocket costs for beneficiaries affected by improper conduct. Some such remedies already exist, e.g., in the nursing home context.

As has been indicated, however, any sanctions will be of limited effect unless the public is aware of them. We recommend the following:

(1) HCFA should prepare and submit a report describing all sanctions heretofore imposed against lock-in HMOs, indicating the nature of the problem giving rise to each sanction. Any such report could refer to aggregate numbers of similar kinds of problems/sanctions (e.g., "50 enrollees, claiming no knowledge of enrollment, retroactively disenrolled and Medicare paid for services") for simplicity's sake.

(2) HCFA should publish, in a manner accessible to consumers, a statement of the remedies and sanctions available to redress beneficiary problems, the circumstances to which they apply, and the means for obtaining them.

(3) HCFA should propose, for public comment, and adopt in timely fashion, a broadened range of intermediate sanctions.

D. MARKETING AND ENROLLMENT

My testimony has stressed that there is a significant problem of beneficiaries being enrolled in HMOs either without their knowledge or without adequate understanding of HMO rules and conditions such as the lock-in. Since the hearing, I learned one other fact on point which I would like to cite for the record.

Some months ago, one California HMO voluntarily obtained retroactive disenrollment of about 5% of its initial 10,000 Medicare enrollees. The HMO itself—after being apprised of out-of-plan services used by these individuals—apparently agreed that they were enrolled without adequate knowledge. This 5% consists solely of enrollees brought to the HMO's attention, and who the HMO elected to disenroll, and doubtless underestimates the magnitude of the problem.

The HMO in question should receive credit for initiating this action. Other HMOs, about which there is no evidence to suggest that the situation is any different, have not behaved similarly. However, such actions do not reach other enrollees, whose inadequate knowledge may lead to underutilization of HMO services, but who have not yet been identified or solicited. In addition, these actions have not resolved the matter of out-of-plan services coverage for these beneficiaries.

My pre-hearing testimony urged that steps must be taken to assure an enrollee's physical, tangible contact with an HMO before the lock-in is allowed to be effective (and before the HMO should be entitled to receive capitation payments). Thousands of beneficiaries are "enrolled" by HMOs, yet never visit them. While ludicrous on its face and inconsistent with an informed enrollment, this is also inconsistent with provisions of the preventive services which HMOs are, by law, required to provide.

E. RELIEF FOR THOSE HARMED

My testimony has repeatedly stressed the fact that at least 15,000 Medicare beneficiaries became personally liable for out-of-plan services during the conduct of HCFA's experimental project. Despite agency representatives' declarations to the Subcommittee that the problems revealed by the experiment have been corrected, in fact, no relief has been provided for those individuals.

The plight of these individuals has been long known to HCFA. Barring any inadequacies in the data processing records where HCFA has not acknowledged, their identities can be determined. We again ask the agency to resolve those individuals' situations.

HCFA representatives testified that the problems revealed by the demonstration project have been identified and corrected. Inasmuch as the agency had already chosen to enter into new "TEFRA" contracts with all the Demonstration HMOs several weeks before the hearing,[7] any other response would have been a surprise.

With all due respect to HCFA's work in this area, I think it's clear that the picture is nowhere near as rosy as the agency would have us believe. Most of the matter raised in my testimony, and at the hearing, are matters which could and should have been addressed long before today. HCFA's reassurances at the hearing were comforting, but, as in most things, actions speak louder than words.

Respectfully submitted,

MICHAEL C. PARKS, *Staff Attorney.*

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, May 15, 1985.

Re Problems Associated with Federal Administration of Medicare Participating Health Maintenance Organizations and Competitive Medical Plans.

Hon. CAUDE PEPPER,
Chairman Subcommittee on Health and Long-Term Care, House Select Committee on Aging, House Office Building, Washington, DC.

DEAR CHAIRMAN PEPPER: The American Medical Association takes this opportunity to submit this letter for inclusion in the hearing record from your Subcommittee's April 24, 1985 hearing on the participation of health maintenance organizations (HMOs) and competitive medical plans. (CMPs) in the Medicare program. The AMA has a number of concerns with the implementation of this program on a nationwide scale, and we urge a delay in the full scale implementation of the regulation authorizing such broad participation of HMOs and CMPs in the Medicare program.

The American Medical Association believes that there are ample reasons for congressional action to delay the nationwide implementation of the regulations authorizing Medicare coverage for services provided through HMOs and CMPs: 1) these regulations will result in the Medicare program incurring substantial additional expenses at a time when virtually every aspect of the program is being examined for means to achieve budget savings; 2) the implementing regulations underwent substantial modifications without any opportunity for public comment on the revised regulations; and 3) there is a general lack of information from demonstration projects designed to determine the ability of HMOs and CMPs to provide necessary care for Medicare beneficiaries.

The American Medical Association believes that these issues warrant a delay in the implementation of these regulations. The AMA presented a statement to the Health Care Financing Administration on February 20, 1985 that goes into greater detail on the three points raised above. We still believe that these arguments are valid, and we are enclosing a copy of our detailed statement to the Health Care Financing Administration (HCFA) for inclusion in the record.

In addition to the points raised in our earlier comments to HCFA, we believe it important for this Committee to consider the General Accounting Office's (GAO) recent report on "Problem in Administering Medicare's HMO Demonstration Projects in Florida." This report points to "systemic problems" in the HMO/CMP methodology in providing Medicare coverage and the report calls on HCFA to act to identify and correct these problems. The AMA shares many of the concerns identified by the GAO, and we believe that they also illustrate that the wisest course of action is to delay implementation of the regulations.

The GAO report is an initial one, and four additional issues will be examined by the GAO concerning the HMO demonstration projects in Florida. The GAO plans to evaluate the methodology of marketing and enrollment, actions taken to assure that quality care is provided by the HMOs and CMPs, the contracting arrangements

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[7] In most, if not all cases, no such new contract was required by law for at least another four months. Subject to HCFA information to the contrary, there is no evidence that any of the HMOs were subjected to special inquiry, re-inspection, etc. prior to the contracting. In its rush to enter into the new contracts, HCFA did not, for example, even require the HMOs about which I have information to remedy their inadequate and invalid appeals processes.

made between HMOs/CMPs and the health care providers including hospitals and medical specialists, and the reasonableness of the HMO payment rates. We believe that the GAO's analysis of these issues can have a substantial effect on how regulations should be drafted to authorize wide scale availability of HMOs/CMPs as a health care coverage source for Medicare beneficiaries. This is especially true in light of the large number of ongoing demonstration projects that are supposed to examine many of these same issues. The AMA strongly recommends that this GAO follow-up report be completed, analyzed, and acted upon where appropriate prior to the full implementation of the regulations.

There are substantial questions concerning the benefits to be derived by the implementation of these regulations. We would be pleased to discuss this matter further if you so desire.

Sincerely,

JAMES H. SAMMONS, M.D.
Executive Vice President.

Enclosure.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION

Re File Code BERC-247-FC, Final Rule With Comment Period: "Medicare Program; Payment to Health Maintenance Organizations and Competitive Medical Plans," Federal Register of January 10, 1985 (50 F.R. 1314)—February 20, 1985

The American Medical Association takes this opportunity to submit these comments on the "Final Rule with Comment Period" concerning payment to health maintenance organizations (HMOs) and competitive medical plans (CMPs). The AMA believes that these regulations need further study and that their implementation should be delayed.

In calling for delay in the implementation of these regulations, we feel it is important to raise three issues for your consideration: the extensiveness of modifications made by the Department between the Notice of Proposed Rulemaking (NPRM) and this Final Rule with Comment Period; the lack of information from ongoing demonstration projects concerning the provision of health care services by HMOs and CMPs for Medicare beneficiaries; and the projected additional expense to the Medicare program that will be caused by the implementation of these regulations.

REGULATORY MODIFICATIONS

Between the publication of these regulations as an NPRM and the January 10 publication as a Final Rule with Comment Period, substantial modifications have been made. An analysis of the extent of these modifications set forth in Section VI of the preamble indicates 43 changes having been made. The preamble characterizes these changes as follows: 27 are in response to public comments, 3 are because of modifications in the law, and 13 are labeled as "miscellaneous changes."

As stated elsewhere in the preamble, HCFA expects to address only those comments that are now received in response to the January 10, 1985 Federal Register notice which concerns changes to the regulations brought about by modifications in the law. The AMA believes that this position is highly inappropriate. While some of the changes to the regulations are minor, other modifications have a substantial impact on the provision of health care services to Medicare patients by an HMO or CMP.

For HCFA to state that all elements of these final rules were "proposed in the NPRM" and that the January 10 Federal Register publication provides a response to "comments received on these provisions" totally overlooks the fact that major modifications have been made in these regulations without an additional opportunity for public input. Also, some of the modifications raise totally new concepts and were never before the public during the comment period. For example:

Substantial modifications have been made to the provision concerning marketing activities, Section 417.428. The provision requiring brochures, application forms, and promotional and information material to be submitted to HCFA for approval has been deleted. The prohibition of practices that are "discriminatory or unethical" has been modified substantially so that only discriminatory practices are specifically prohibited.

The regulations authorize HMOs and CMPs expanded authority at Section 417.460(a)(6) to disenroll Medicare beneficiaries.

Section 417.531 and Section 417.585 establish new provisions setting forth the role of the HMO or CMP when one of its beneficiaries elects hospice coverage under the Medicare program.

The final regulations also add an entirely new Subpart D concerning health care prepayment plans, or organizations that are specifically established to provide only those services normally covered under Part B of Medicare.

The modifications described above are merely examples of some of the modifications made between issuance of the Notice of Proposed Rulemaking and the Final Rule.

While some of the modifications made reflect an improvement in the regulations, serious questions could readily be raised over many aspects of the modifications. For example, the AMA believes that the review of promotional materials is of critical importance in protecting Medicare beneficiaries. as noted above, HCFA has deleted the requirement of prior approval for such materials. We believe such a review is most important in light of some previous promotional activities. Promotional material was the subject of a lawsuit brought by Dade County Medical Association against a local HMO and the Department of Health and Human Services. In that particular instance, a court order was entered in 1983 that set forth guidelines for future promotional materials to be distributed by the HMO to assure that those materials would not be misleading. Partially as a result of that court order, HCFA's Group Health Plans Operations staff had routinely reviewed promotional material to assure that they would be clear and accurate.

Changes in the regulations in this and other aspects will have a substantial bearing on the provision of health care services for those Medicare beneficiaries electing this form of health care delivery. HCFA's failure to solicit comments on the substantial modifications, such as the reversing of its position on promotional materials, is highly inappropriate and should be reversed. Given the fact that the preamble to the regulations project that as many as 800,000 Medicare beneficiaries will enroll in HMOs and CMPs as a result of these regulations, we believe that every effort should be made to solicit views on major changes.

DEMONSTRATION PROJECTS

The American Medical Association does not believe that these regulations should be implemented on a nationwide scale at this time. There currently are a large number of ongoing demonstration projects that are designed to investigate substantial issues that demand clarification prior to implementation of these regulations. Important questions on such topics as the quality of care provided by an HMO or CMP for Medicare beneficiaries and the viability of the 95% AAPCC reimbursement formula are still awaiting answers.

The Health Care Financing Status Report, Research and Demonstrations in Health Care Financing (April 1984 edition) indicates that there are at least twenty-eight ongoing investigations that have a direct bearing on this subject. Of these twenty-eight investigations, only one has a scheduled completion date in 1985; three are due to be completed in 1986; twenty-three are due to be completed in 1984; and one is due to be completed in 1988.

In addition to the substantial number of ongoing demonstration projects, we note that HCFA has again called for further demonstrations into the provision of health care services for Medicare beneficiaries by HMOs or CMPs. In the Federal Register of January 30, 1985, HCFA issued a notice of the availability of another $9 million in federal funds for further research in this area.

HCFA has already committed a substantial sum to complete the ongoing demonstration projects. Funding of $6,761,311 has been allocated for just seven of the twenty-eight projects. Almost half of this funding is going to a single project being conducted by Mathematica Policy Research, Inc. This expensive study is supposed to include an analysis of over 50 HMOs and CMPs providing care to Medicare beneficiaries for a prospectively determined payment. One of the issues this study is supposed to focus on is the impact of enrollment of Medicare beneficiaries by CMPs under risk-based capitation on the use, quality, and cost of care. With important questions such as this yet to be answered, and with the Mathematica study not scheduled to end until December 1987, we believe it is premature for these regulations to be implemented on a nationwide basis.

It is indeed unfortunate that these regulations seek implementation of an unproven system. As no demonstration project has operated on even a statewide basis, we believe it is irresponsible and inappropriate to fail to ascertain the impact these particular regulations will have on a limited basis prior to their being imposed on a national scale. The regulations should be deferred until results of evaluations are analyzed.

ADDITIONAL PROGRAM EXPENSE

The AMA believes that serious questions must be raised concerning the propriety of the Department's efforts to implement these regulations at this time. The implementation will result in substantial additional expenditures for the Medicare program. According to the preamble to these regulations, "net Medicare program costs would increase by $30 million in fiscal year 1985 and $65 million in fiscal year 1986 as a result of the NPRM." At a time when every expenditure under the Medicare program is coming under careful scrutiny and with proposals being considered to reduce Medicare expenditures dramatically, it is inappropriate for HCFA to implement new and costly regulations.

In addition to our concerns over the projected total expense of these regulations, others have questioned whether there are problems with the HMO/CMP reimbursement methodology. As pointed out in the New England Journal of Medicine on January 10, 1985, the General Accounting Office is currently engaged in an investigation of a Florida HMO that has been providing care to Medicare beneficiaries under a demonstration project. The article quotes a letter from Congressman Larry J. Smith (D-FL) that urges the Administration to delay publication of the final Medicare/HMO regulations pending a final report from the GAO. Congressman Smith points out that the GAO report may point to systematic flaws within the HMO reimbursement methodology that could be costing the program millions of dollars. The AMA agrees with the concerns of Congressman Smith, and we join in asking that the implementation of these costly regulations be delayed.

CONCLUSION

The American Medical Association believes that there are ample reasons to delay implementation of these regulations. The Association is particularly concerned that these regulations are being implemented without full consideration by HCFA of the public's concerns. The additional expenditure that will result because of these regulations and the fact that there is a growing body of information concerning the provision of health care by HMOs and CMPs leads us to the conclusion that there is more to be gained by delaying implementation than by the planned course of action. The American Medical Association is eager to discuss these issues with the Department, and we urge your rapid consideration of our request to delay the implementation of these questionable and costly regulations.

AMERICAN ASSOCIATION OF RETIRED PERSONS,
Washington, DC, May 7, 1985.

Hon. CLAUDE PEPPER,
Chairman, Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for this opportunity to state the American Association of Retired Persons' views on the implementation of the health maintenance organization (HMO) benefit under Medicare. Like you, the Association believes that timely attention to the administration of this new benefit is important for the development of an efficient and reliable Medicare/HMO system.

The United States Government Accounting Office (GAO) Report on the Problems in Administering Medicare's HMO Demonstration Projects in Florida, (March 8, 1985) is instructive in identifying problems that have been encountered in implementing this new Medicare benefit. This letter focuses on three issues identified in the GAO Report. The issues are: (1) communications among the principle decision makers in the Medicare/HMO system, i.e., the Medicare intermediaries and carriers, HCFA, and HMO's (2) HCFA's capacity to process HMO data accurately and within a reasonable time, and (3) beneficiaries understanding of their rights and responsibilities under the HMO system. A brief description of AARP activities regarding HMOs concludes this letter.

(1) COMMUNICATION

The GAO Report identifies serious communication problems among the key decision makers operating in the Medicare/HMO system; HMO's, Medicare intermediaries and carriers, and HCFA. Failure by these key decision makers to keep each other informed about the status of beneficiaries or claims resulted in significant payment errors. For example, Medicare carriers paid 29 percent of the charges for physician services delivered to HMO enrollees outside of the HMO. These were duplicate payments because the costs of the services were included in the payment

rate to the HMO. Such errors occurred because HCFA could not provide Medicare carriers with timely and accurate information about the HMO enrollment status of beneficiaries.

Failure of communication led to other problems in the Medicare/HMO system identified by the GAO. Medicare carriers are instructed to transfer to the HMO out-of-plan claims that are denied. Compliance with this instruction is important because the HMO may have authorized the services, or the services may have been provided under circumstances where the beneficiary is without fault. In either situation, failure of the carrier to transfer the denied claim to the HMO can result in unnecessary out-of-pocket costs to Medicare beneficiaries. Moreover, if the HMO is not aware of these out-of-plan claims it cannot target enrollee information and training on the real problems.

(2) HCFA'S CAPACITY TO PROCESS DATA

HCFA's timely and accurate recording of beneficiaries enrollments and disenrollments from HMO's is the linchpin of the Medicare/HMO system. HCFA's failure to accurately track and record in a timely manner beneficiaries' enrollments and disenrollments in HMO's was a major source of the payment errors encountered in Florida. Payment errors are not only disruptive to the program and providers, they can cost beneficiaries dearly in greater out-of-pocket costs for health care.

The Secretary of Health and Human Services should direct the Administrator of HCFA to take the actions necessary to administer this new benefit accurately and in a timely manner. Despite the complexities of the Medicare/HMO system, AARP believes that timely communications and coordination among the key decision makers in the system is possible. Both the hardware and software necessary to facilitate such communication is readily available. A stable and reliable information system must be developed if the Medicare/HMO benefit is to become an important alternative to Medicare beneficiaries.

(3) BENEFICIARIES UNDERSTANDING OF THE SYSTEM

AARP is pleased that beneficiaries participation in the Florida HMO demonstration projects understood, for the most part, their responsibilities in the HMO system. According to the GAO report, less than 6.5 percent of the beneficiaries screened received out-of-plan services while enrolled in an HMO. This demonstrates that beneficiaries understand and accept the "lock-in" rules.

There is confusion, however, among beneficiaries and HMO's, about who pays for services provided to beneficiaries hospitalized after HMO enrollment, but before the effective date of HMO membership? In this situation, AARP believes that the regular Medicare should be responsible for all costs until the patient is discharged and the monthly capitation payment is proportionately reduced for the days involved.

There is similar confusion about who pays for out-of-plan services provided to a beneficiary after they signed the HMO disenrollment form but before the effective date of disenrollment? AARP agrees with the GAO that regular Medicare coverage should be available for those beneficiaries receiving necessary services during the waiting period between the date they apply for disenrollment and the effective date of disenrollment.

Finally, Mr. Chairman, I would like to briefly describe AARP's efforts to inform our membership and others about the HMO alternative.

In 1984, AARP began the HMO Informed Buyers Project. The purpose of the project is to increase older consumers' awareness and understanding of health maintenance organizations. The project trains volunteer trainers to provide such consumer education on HMOs.

To date, over 110 volunteers have participated in three day training sessions in five cities around the country. Information and training included the following subjects: description of HMO structure, services and requirements; advantages and disadvantages of HMO membership; planning, publicizing and conducting a consumer education project; questions and answers with local HMO representatives. Medicare enrollments in HMOs and changes in HMO premiums and benefits for Medicare beneficiaries.

Making the Medicare HMO option a successful and viable alternative to fee-for-service medical care requires the efforts of HMO providers, beneficiaries and federal government. AARP congratulates you, Mr. Chairman, on your leadership to make the HMO option work for Medicare beneficiaries.

Sincerely,

SANA F. SHTASEL,
Director, Federal Affairs.

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